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Phase I

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THE MONTANA PRELIMINARY STATE HEALTH PLAN

september, 1978

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Department of Health and Environmental Sciences
STATE OF MONTANA HELENA MONTANA 59601

A C Knight M D F C C P
Director

September 21, 1978

Dr. Bryce Hughett
Chairman
Montana Statewide Health
Coordinating Council
1245 North 29th
Billings, Montana 59101

Dear Doctor Hughett:

Submitted herewith is the draft Phase I of the Montana Preliminary State Health Plan.

We are requesting the Council's authorization to submit copies of the document to the appropriate Legislative Committees.

Further, we request review, comment and recommendations as to format and content of the PSHP, not later than October 27, 1978.

This will permit us to incorporate changes in the second phase of the PSHP.

Sincerely,

Wallace A. King, Chief
Bureau of Health Planning
& Resource Development

WAK:se

cc: A.C. Knight

EEO/AFFIRMATIVE ACTION AGENCY

"ALL PERSONS ARE BORN FREE AND HAVE CERTAIN INALIENABLE RIGHTS. THEY INCLUDE THE RIGHT TO A CLEAN AND HEALTHFUL ENVIRONMENT AND THE RIGHTS OF PURSUING LIFE'S BASIC NECESSITIES, ENJOYING AND DEFENDING THEIR LIVES AND LIBERTIES, ACQUIRING, POSSESSING AND PROTECTING PROPERTY, AND SEEKING THEIR SAFETY, HEALTH AND HAPPINESS IN ALL LAWFUL WAYS. IN ENJOYING THESE RIGHTS, ALL PERSONS RECOGNIZE CORRESPONDING RESPONSIBILITIES."

CONSTITUTION OF THE STATE OF MONTANA, 1972
(ARTICLE II, SECTION 3)

SECTION I

INTRODUCTION

TO THE

MONTANA

PRELIMINARY

STATE HEALTH PLAN

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PROLOGUE

The Preliminary State Health Plan reflects the efforts of consumers, providers, and representatives of State government to mutually address the problems of accessibility, availability, cost, quality, and continuity of health care services in Montana. The Plan was developed by the State Health Planning and Resource Development Agency (SHPDA) working under the direction of the State Health Coordinating Council (SHCC). All attempts have been made to include input from the Health Systems Plan, prepared by the Montana Health Systems Agency, Inc., as well as the plans and policies of the various units of state government involved in the delivery of health services.

This Preliminary State Health Plan and the Final State Health Plan are not intended to be documents which mandate changes in consumer/provider behavior, nor are they an attempt to force change in Montana's health system. Rather, it is the hope of the SHPDA and SHCC that the State Health Plan will be used as the central framework for enhancing and improving the current system. This Plan is the first step in meeting the health care needs of Montana's citizens.

I. INTRODUCTION

A. AN OVERVIEW

The Preliminary Montana State Health Plan for 1979 serves as a basis for future planning by the Montana SHCC, SHPDA, and all health-related agencies and groups within state government. The Plan addresses statewide health needs, concentrating on the plans and priorities of state government. The overall purpose of the Plan is to encourage more efficiency and effectiveness in state health programs. The following general premises were adhered to in the development of the Plan:

--Health is a state of physical, mental and social well-being to which the individual has both a right and a responsibility. The right to health entitles the individual to a safe health environment and to high quality, readily accessible health care at a reasonable cost. This responsibility means that the individual must practice good health maintenance habits, must appropriately utilize the health care system, and must be involved in health policies to ensure public health.

--While planning and evaluation are necessary at many levels, they begin at the program level. Health-related programs have both a right and a responsibility to conduct their own planning and evaluation. This right entitles the individual program the freedom to choose its own course of action without unnecessary outside interference. This also means that the individual program must determine its own needs, decide a course of direction, coordinate with other programs, and be accountable for its own progress.

With these premises in mind, the Preliminary State Health Plan has been developed as a broad policy document with the following objectives:

--To articulate Montana State government's health and health-related policies and programs;
--To provide information related to health care funding, both federal and state expenditures;
--To guide the development of a coordinated approach to identification and resolution of health problems associated with achieving access to health care at a reasonable cost; and
--To guide the State in the allocation of health care resources.

More specifically, the SHPDA and SHCC will use the State Health Plan in performing the duties, listed below, which are mandated under the National Health Planning and Resource Development Act (P.L. 93-641).

1. To guide the development of statewide health programs and priorities which each agency and group within State government should be working toward.

2. To develop a coordinated, comprehensive approach to the identification and resolution of health problems, including the development of statewide priorities.
3. To provide health status, socio-economic, performance and expenditure data which can be used as a basis for examining resource allocations.
4. To provide criteria for review of health agency plans and appropriateness of institutional services.

The Preliminary State Health Plan for 1979 is only the first step toward Montana State government's efforts to plan for the health needs of Montana citizens. It provides the data and processes for future planning and evaluation efforts. To ensure the viability of the Plan, it will be expanded in future years to include more in-depth planning information, as well as problem-oriented, population-based analysis of specific health problems.

B. HEALTH PLANNING - A DEFINITION

For those unfamiliar with the concept of health planning, the term may bring to mind an outlined, daily regimen of diet, exercise and medication. In the pure sense of the term, on a personal level, this is true. But, as used here, the term refers to a political process in which those who receive health care, those who provide it, those who pay for it, and those who monitor it, should join together to decide the direction for a meaningful health care system.

Not so long ago, health care involved primarily the individual or the individual and his/her doctor. But as the health care system became increasingly complex, it also became politicized. Health care now involves the individual, and a multitude of providers, administrators, third-party payors, and governmental agencies. Although the responsibility for maintenance and improvement of one's health still lies primarily with the individual, as a taxpayer, insurance policy holder, or user of the health care system, each individual has an interest in the politics of health care.

Health planning is a forum for the individual to join with others to coordinate services and to determine where and how health care dollars should be spent. Planning occurs at many levels; personal, institutional, community, county, regional, state and national. Although health planning is a dynamic process, it is a means to an end, not an end in itself. The ends, or goals, sought through health planning, depend on the actions of those involved. A complete description of the process used for developing the Preliminary State Health Plan appears in "F" of this Section.

C. HISTORY OF HEALTH PLANNING IN MONTANA

Health care providers and consumers in Montana have joined together for many years to discuss health issues and to plan the direction of the health care system. In 1946, Congress passed the Hill-Burton Act for the development of hospital construction to meet shortages resulting from the depression and World War II years. The Hill-Burton Act was amended in 1964 to include funding for nursing homes, rehabilitation and ambulatory care facilities, chronic disease hospitals, and replacement and modernization of existing facilities.

In 1965, Congress created the Regional Medical Programs (RMP) (P.L. 69-239) which were envisioned as the result of a 1964 report of the President's Commission on heart disease, cancer and stroke. RMP's were to develop cooperative arrangements among health care institutions medical schools, and research institutions with the goal of bringing the latest improvements in technology for treatment of heart disease, cancer, and stroke patients. This was the beginning of focusing on specific diseases, primary care concerns, regionalization of health care resources, and expanded use of health manpower in medically underserved areas.

The following year, 1966, Comprehensive Health Planning (CHP) was established under P.L. 89-749. The CHP created new sections, 314 (a) and 314 (b), to the Public Health Services. This Act provided for financial resources at the State ("a" agencies) and sub-state ("b" agencies) levels for the purpose of carrying out planning, project review activities, and coordination activities. The agencies generally lacked the power and resources to implement plans developed. With emphasis on the planning process, rather than upon implementation, Congress and others grew concerned over the impact of the invested financial resources and began to develop the Act which is now known as P.L. 93-641.

Over one-half billion dollars was channeled through the Regional Medical Programs from 1966 through 1974 for development efforts. Regional Advisory Boards, representing a state or sub-state region, directed the expenditures of these federal funds. However, ties to other planning agencies such as "b" and "a" agencies were not sufficiently formal to ensure any linkages and, consequently, independent, often conflicting actions were taken by the RMP's and CHP "a" and "b" Councils.

The Social Security Act was amended in 1972 to include Section 1122, which provided for Medicaid and Medicare payments. This section allowed the Federal Government to withold Medicare and Medicaid reimbursements to facility owners unless approval by the designated state health planning agency ("a" agency) had been given prior to capital expenditures totaling over $100,000.

In an attempt to strengthen health planning and review activities, the U.S. Congress combined the Comprehensive Health Planning Act, the Hill-Burton Medical Facilities Construction Program, and the Regional Medical Program into the National Health Planning and Resource Development Act of 1974 (P.L. 93-641). This Act created a network of local Health Systems Agencies (HSA's),state level Health Planning and Development Agencies (SHPDA's), and Statewide Health Coordinating Councils (SHCC's) in each state. The law directed each Governor to designate a SHPDA to "conduct the health planning activities of the state", and to appoint a group of health care providers and consumers to the SHCC to advise the SHPDA and the Governor.

Governor Thomas L. Judge designated the Bureau of Health Planning and Resource Development, of the State Department of Health and Environmental Sciences, as the SHPDA in 1976, and then appointed 18 members to the SHCC. The SHPDA replaced the former CHP office and the SHCC replaced the former State CHP Advisory Committee.

In addition to the SHCC and SHPDA, P.L. 93-641 required the establishment of a Health Systems Agency (HSA). Because the law set higher population quotas for areas served by HSA's than for those served by the old CHP agencies, one HSA was formed to serve the entire State of Montana. It is the Montana Health Systems Agency, Inc., a non-profit corporation. As outlined in P.L. 93-641, the Health Systems Plan (HSP) is developed by the HSA and emphasizes improved health through the establishment of goals and objectives for the entire health system. The resources and actions necessary to achieve these goals and objectives take into account the national guidelines which focus on the supply, distribution, and organization of health resources and services. A summary of the Health Systems Plan will be included in the Preliminary State Health Plan, Phase II. The HSA is currently working on their document, (see Appendix).

In general, the National Health Planning and Resource Development Act of 1974 gives the health planning structure more power to enforce plan implementation than was previously possible under other legislation. Each agency established under P.L. 93-641 has decision-making and regulatory authority over certain segments of the health delivery system. By working together, these agencies can form an effective network for planning and implementing health care services.

D. INTEGRATED PLANNING AND EVALUATION

As agencies responsible for the planning and implementation of comprehensive health care services, the SHPDA and SHCC must assure that optimum use is made of all available resources. This requires that they be aware of the plan in concert with those programs whose funds do not pass through them, in addition to those programs over which they have either an advisory or decision-making role.

In order to accomplish this, the SHPDA and SHCC must form working relationships with a variety of agencies and groups throughout the State. Some of these groups are:

- Governor's Office of Budget and Program Planning
- State Legislature
- Divisions of Bureaus in the Department of Health & Environmental Sciences
- Other State departments involved in the provision of health services.
- Local Health Departments
- Montana Foundation for Medical Care
- Montana Medical Association
- Montana Hospital Association
- Montana Nursing Home Association
- Montana League for Nursing
- Voluntary health agencies
- Public and private health facilities

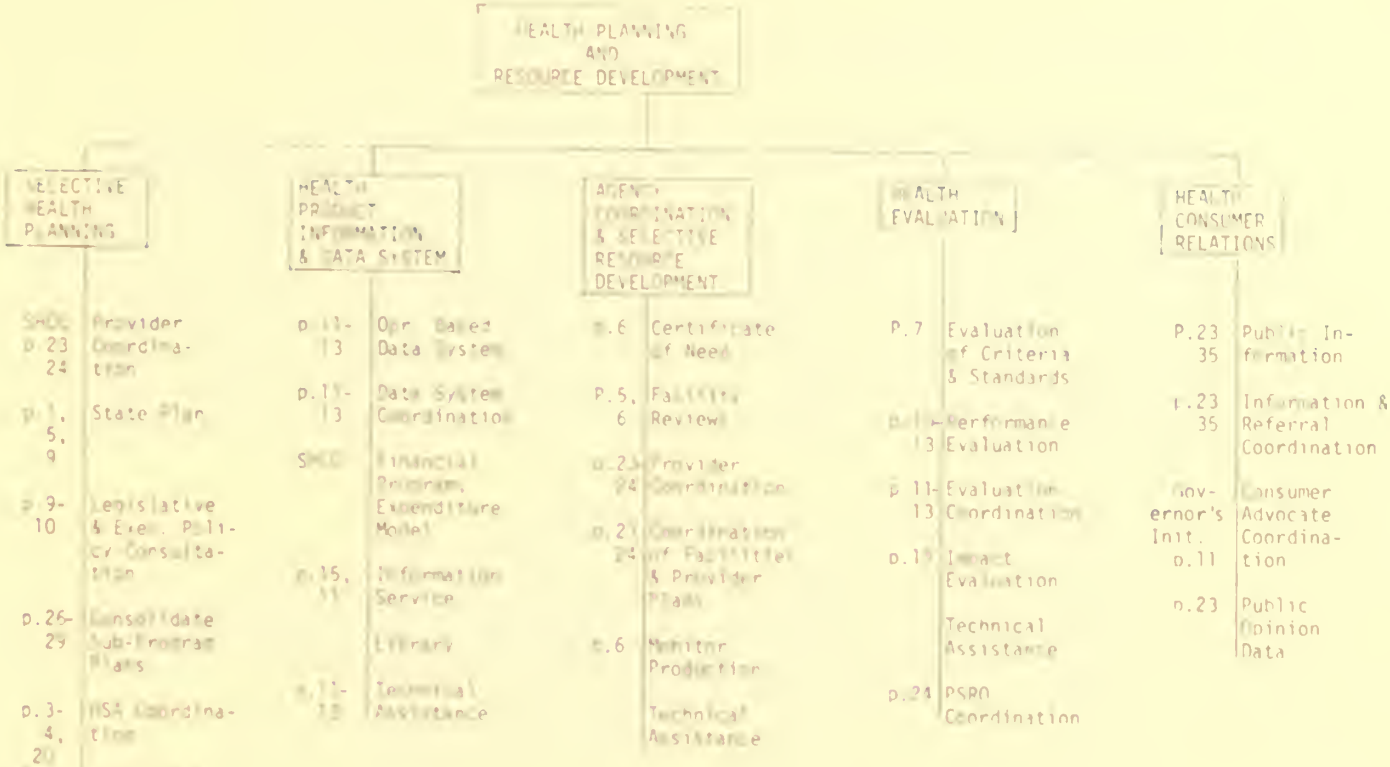
The development of an integrated planning and evaluation strategy is a prerequisite to the implementation of a coordinated, effective, statewide health care system. As can be seen in Table 1, the SHPDA is currently developing integrated planning and evaluation models, which, if approved by the SHCC, will be used in the annual development of the State Health Plan. These models will facilitate more complete and accurate input from agencies such as those listed above.

During Fiscal Year 1979, the SHPDA will pilot these models with several selected programs in order to test the models and to develop improved planning and evaluation information. Each year the SHPDA will work with several programs and, using these models, present a more accurate picture in the State Health Plan of the needs and priorities of these programs.

Planning and evaluation information developed under the models will be used by the programs to strengthen their ongoing operations. The SHPDA will use the information in the development of the State Health Plan and in the implementation of other activities such as review for Planned Use of Federal Funds (PUFF) and the Certificate of Need program. Other programs involved in planning, evaluating, and coordinating health-related programs will also find this information useful. For example, the Governor's Office of Budget and Program Planning administers the Executive Planning Process. This process requires that each Division and Bureau in state government submit a statement of its mission, goals, objectives, priorities, and problems to the OBPP for use in the development of the State budget. Once the OBPP has completed the budget, it

Table 1

HEALTH PROGRAM COORDINATION
PLANNING AND EVALUATION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SHPDA

STATE HEALTH PLANNING & DEVELOPMENT AGENCY
RESPONSIBLE FOR THE HEALTH OF MONTANANS
HEALTH MARKETING

*p.
Page numbers of reference in Guidelines for the Development of the State Health Plan DHEW, 1977

is sent to the Legislative Fiscal Analyst who reviews all state government work programs and budgets and recommends funding priorities to the Legislature. The integrated planning and evaluation models will be used to strengthen the Executive Planning Process so that both the Governor and the Legislature can make funding recommendations on more accurate and pertinent information.

E. FUNCTIONS OF THE MONTANA SHCC, SHPDA AND HSA

As was discussed in Section I.C., Montana's SHCC, SHPDA, and HSA's were formed according to P.L. 93-641. Because this law was promulgated to strengthen health planning, it mandated certain roles and responsibilities for each group. However, because the HSA's service area is the entire state as is the SHPDA's and SHCC's, it was necessary to identify areas of responsibility in order to avoid duplication. Based on negotiations between these groups, the SHPDA and SHCC assume responsibility for matters relating to state government and the HSA will concentrate its efforts in the private health care sector. The following section outlines the functions of each group, as specified in P.L. 93-641

1. The State Health Coordinating Council

Functionally, the SHCC is an advisory committee to the Governor and the SHPDA. Although its primary role is to coordinate services, it does have review and approval authority over certain categories of federal functions.

According to P.L. 93-641, the SHCC's functions are to:

a. Annually review, comment on and coordinate the plans of the Health Systems Agency;
b. Prepare, review and revise at least annually, a State Health Plan;
c. Annually review and comment upon the budget of the Health Systems Agency;
d. Review and comment upon applications for federal grants to the HSA:
e. Advise the SHPDA on the performance of its functions;
f. Annually review and approve or disapprove any State plan and any application submitted to Department of Health, Education and Welfare as a condition to the receipt of any funds under allotments made to the State under P.L. 93-641, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

2. The State Health Planning and Development Agency

The SHPDA is a part of the Executive Branch and therefore is directly responsible to the governor. In addition to its planning

and evaluation functions, it also provides technical assistance to other state and local agencies.

The SHPDA has regulatory powers in matters of capital expenditures or changes in services over hospitals, nursing homes, and home health agencies.

The duties of the SHPDA, as outlined in P.L. 93-641, are to:

a. Conduct the health planning activities of the State;
b. Develop and revise at least annually, a preliminary State Health Plan;
c. Implement those parts of the State Health Plan and the plans of the Health Systems Agencies within the State that relate to government of the State;
d. Develop and annually revise and administer a State Medical Facilities Plan;
e. Coordinate all health planning data activities within the State;
f. Serve as the designated planning agency for capital expenditure review under Section 1122 of the Social Security Act;
g. Administer a State Certificate of Need Program;
h. Review and make findings concerning all new institutional health services in the State;
i. Periodically review the appropriateness of existing institutional health services;
j. Administer federally-assisted facilities construction activities in the State;
k. Assist the SHCC in the performance of its functions.

3. The Health Systems Agency

The functions of the Montana Health Systems Agency are similar in many ways to those of the SHCC and SHPDA. But it assumes primary responsibility for matters related to the private health care sector.

Specifically, its duties are to:

a. Provide effective health planning for its service area and promote the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency;
b. Assemble and analyze health data;
c. Establish, annually review and amend as necessary a Health Systems Plan;
d. Establish, annually review and amend as necessary an Annual Implementation Plan (AIP);
e. Develop and publish specific plans and projects for achieving the objectives established in the AIP;
f. Implement its HSP and AIP;

g. Make grants to public and non-profit agencies to assist them in developing projects and programs necessary for the achievement of goals of the HSP (dependent on availability of Area Health Development funds);
h. Coordinate with the Professional Standards Review Organization, appropriate regional planning or administrative agencies and any other appropriate entities in its service area;
i. Review and approve or disapprove each proposed use within its service area of federal funds appropriated under P.L. 93-641, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970;
j. Provide to each Indian tribe or inter-tribal Indian organization within its service area information about the availability of Federal health funds;
k. Review and make recommendations to the SHPDA on the need for proposed new institutional health services in its service area;
l. Periodically review and make recommendations to the SHPDA on the appropriateness of existing institutional health services;
m. Recommend to the SHPDA priority projects for modernization, construction and conversion of medical facilities in its service area.

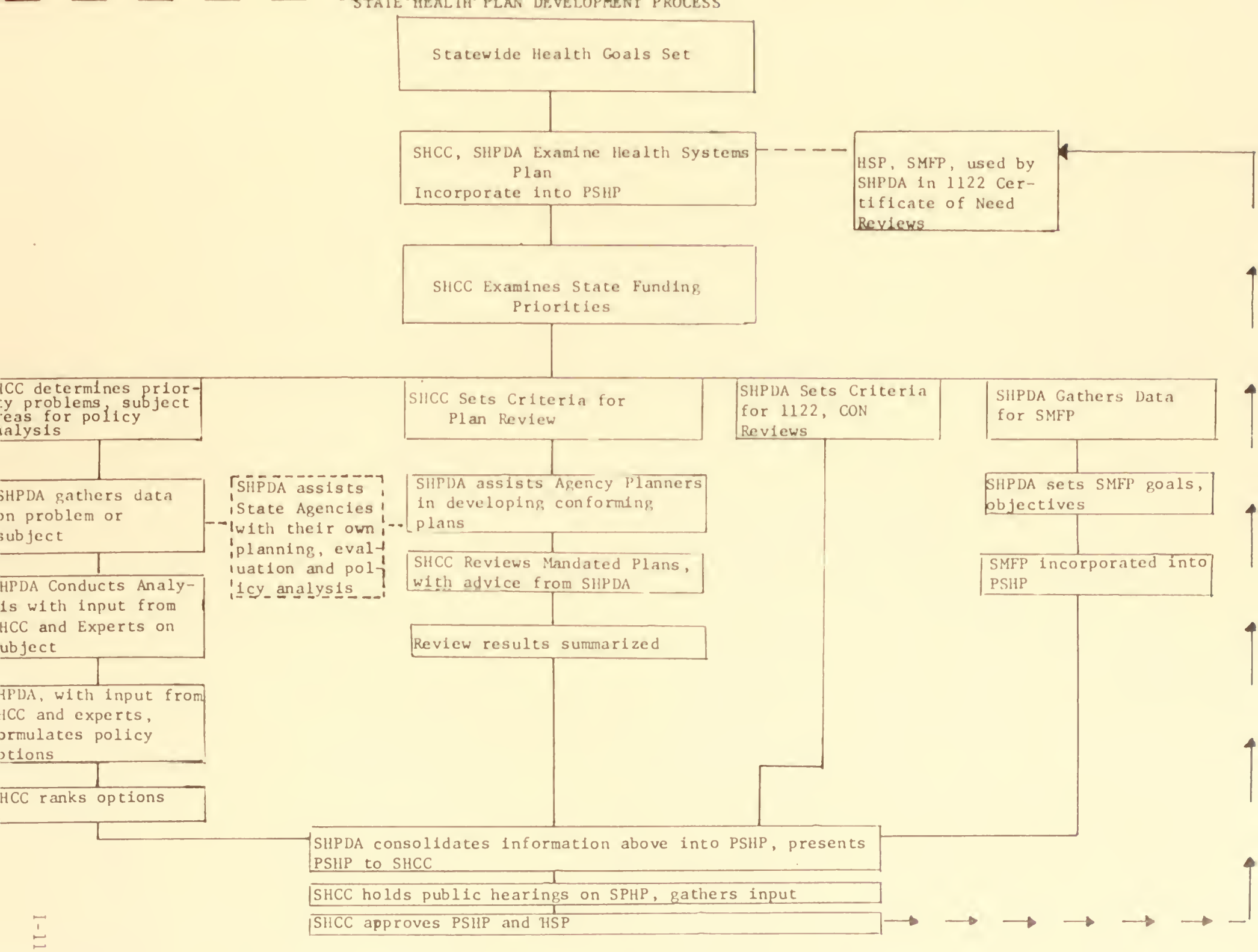
F. PLAN DEVELOPMENT PROCESS

The Preliminary State Health Plan represents the SHPDA and SHCC's efforts to establish a basis for future planning efforts. The process used in the development of the 1979 Plan is presented in Table 2. Although modifications have already been made in the plan development process (see Work Plan, Appendix 2, page 7) the general planning framework and methods used this year will be adhered to in subsequent years. This section will elaborate on some of the steps used this year and will discuss activities planned for subsequent years.

Goal and Priority Setting -- This process involved soliciting citizen input from five subareas of the state and analyzing the needs and priorities identified by the HSA and other state agencies. This input was used to determine the statewide goals. In subsequent years, additional meetings will be held in order to get input from providers and consumers on health needs and priorities.

Incorporation of the Health Systems Plan -- The SHPDA reviewed the Health Systems Plan before incorporating it into the State Health Plan. The HSP will be used to assist the SHPDA in its review of various expenditure and construction requests, and to assist the SHCC in reviewing program plans and applications.

STATE HEALTH PLAN DEVELOPMENT PROCESS


Statewide Health Goals Set
SHCC, SHPDA Examine Health Systems Plan
Incorporate into PSHP
HSP, SMFP, used by SHPDA in 1122 Certificate of Need Reviews
SHCC Examines State Funding Priorities
ICC determines priority problems, subject reas for policy alysis
SHCC Sets Criteria for Plan Review
SHPDA Sets Criteria for 1122, CON Reviews
SHPDA Gathers Data for SMFP
SHPDA gathers data on problem or subject
SHPDA assists State Agencies with their own planning, evaluation and policy analysis
SHPDA assists Agency Planners in developing conforming plans
SHPDA sets SMFP goals, objectives
HPDA Conducts Analysis with input from HCC and Experts on ubject
SHCC Reviews Mandated Plans, with advice from SHPDA
SMFP incorporated into PSHP
HPDA, with input from HCC and experts, ormulates policy ptions
Review results summarized
HCC ranks options
SHPDA consolidates information above into PSHP, presents PSHP to SHCC
SHCC holds public hearings on SPHP, gathers input
SHCC approves PSHP and HSP

Ongoing Activities that Feed Into the State Health Plan -- Policy analysis began once the SHCC determined areas requiring in-depth analysis. Future policy analysis activities will follow the procedures outlined in Section VII. This year's analysis of Health Education will follow the same general format. The results of a policy analysis are used in the formation of policy options. These options will be ranked by the SHCC and incorporated into the State Health Plan.

The provision of technical assistance is an ongoing function of the SHPDA staff. This year, the staff assisted several agencies whose plans will be submitted to the SHCC for review. Plan reviews, conducted by the SHPDA, will be included in future editions of the State Health Plan.

The establishment of review criteria, which will be used by the SHCC in their reviews of plans and applications, is another ongoing function of the SHPDA. These criteria will be incorporated into the State Health Plan as a reference for agencies whose plans come under SHCC review.

State Medical Facilities Plan -- The State Medical Facilities Plan (SMFP) is the SHPDA's plan for hospital and nursing home bed needs. Data for the plan is gathered from annual reports of hospitals and nursing homes. Once the data are analyzed, goals and objectives are developed and included in the Medical Facilities Plan. The SMFP will be reviewed by the public as part of the final draft of the Preliminary State Health Plan. As of this writing, the SMFP has not been included because the federal guidelines have not been finalized.

SECTION II

SYNOPSIS

OF THE

MONTANA

PRELIMINARY

STATE HEALTH PLAN

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SYNOPSIS OF PRELIMINARY STATE HEALTH PLAN

This is the first phase of the Montana Preliminary State Health Plan developed by the State Health Planning and Development Agency. The document attempts to present a coherent frame of reference within which future planning can be addressed and expanded over a period of time. Issues discussed include areas of State Government activity and support in the health sector; a Montana health profile comprised of population-based health status; goals which integrate the identified health concerns of the Statewide Health Coordinating Council, Health Systems Agency, Federal Government, and the State Planning and Development Agency; and, a policy analysis framework.

The Preliminary State Health Plan has been directed towards the future development of substantive health policy and towards the encouragement of health policy planning in State Government health agencies. With this two-pronged approach, emphasis is placed in the difficult arena of health policy adoption and implementation rather than in that of regulation, program monitoring, and the development of more traditional planning activities. In summary, the State Health Planning and Development Agency's role is to guide the creation and operationalizing of policy, to direct resource allocation, to raise the levels of health quality, and to insure access to health care for all Montana citizens.

The first phase of the Preliminary State Health Plan provides the framework for a beginning in the growth of health policy planning. The second phase will include policy analyses on health education programs provided by State Government agencies and will make recommendations for an improved self-health care system which will permit all citizens to enjoy high quality health and health care.

Health education is a priority concern of the Statewide Health Coordinating Council. Their direct participation is considered a mandatory element in plan development. The first phase of the Preliminary State Health Plan is a basis for that participation, a jumping off point for new directions.

Section III

MONTANA HEALTH PROFILE

Of The

PRELIMINARY

MONTANA STATE HEALTH PLAN

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III. MONTANA HEALTH PROFILE

A general health profile of Montana is essential when addressing health issues. The following section will provide an overview of the state's health status, geography, demography and socio-economic characteristics.

An effort has been made to include trends in population composition and economic growth.

This overview is a summary of a more detailed profile of Montana in the Montana Health Systems Agency's Plan.

A. Health Status

1. Introduction

The "health" or health status of a given population is a complex concept which is too often measured subjectively by individuals looking at only limited numbers of indicators.

A health status indicator is usually a statistic, or a group of statistics measuring a specific disease, condition, or event considered in some sense to represent the general health of an entire population group. For example, the number of people in Montana who die from cancer may be an indicator of the health of Montanans. So could the number of children who have measles, mumps, or chicken pox be indicators of health. It is important to recognize that such statistics are only general indicators of health; they do not actually measure health.

The indicators used in the Health Profile were selected because they are available throughout the state and therefore can be used to compare the "health status" of different geographic areas.

A complete analysis of health status is a complex and time consuming undertaking. For the purpose of this plan various indicators of health have been selected for analysis. The data presented is an initial profile of certain health problems in Montana, and should not be construed as a full health status report. The development of a complete health status analysis methodology is a high priority of the SHPDA and considerable resources will be allocated to this effort in the next several years. Until that time SHPDA staff will continue to update and expand the health profile.

It is the intention of the SHPDA to use this systematic integration of data to complete the following objectives.

a. delineate statewide population-based health status and system goals, recommended actions, resources requirements, and allocations;
b. identify the need for improvements in the quality of health care, planned and delivered;
c. promote disease prevention services; and
d. develop public education/personal health care strategies that lend to more effective utilization of available health services.

2. Methodology

The following methodology was used in the development of the Montana Health Profile. County health rankings of eleven selected indicators were used (pages 30-42 for Quartile Maps), in conjunction with the indicators presented in the Health Systems Plan, as the analytical base for the profile. Indicators selected address health problems, social pathology, and social problems.

Indicators based on objective data were selected and are population-based in order to analyze needs of the population unique or common to the area served. Each indicator was given a weight of "1". The indicators ranked by the Bureau of Records and Statistics are:

a. Lung cancer death rates
b. Uterine cancer death rates
c. Infant death rates
d. Neonatal death rates
e. Post-neonatal death rates
f. Low birth weight rates
g. Cirrhosis of the liver death rates
h. Suicide and homicide death rates
i. Motor vehicle accident death rates
j. Accidents other than motor vehicle death rates
k. Age-adjusted death rates

The indicators used in the Health Systems Plan are:

a. Birth rates
..median age of mother
..sex ratio
..Indian birth rate

b. Death rate
..heart disease
..cancer
..stroke
..accidents
..influenza - pneumonia
..arteriosclerosis
..diabetes
..suicide
..early infancy
..infant mortality

In an attempt to minimize the problem of small numbers for counties with small populations, data for 10 of the 11 indicators have been collected for the five-year period, 1972-1976. Data for the 11th indicator, age-adjusted death rates, are shown for a three-year period 1969-1971. In addition, a summary quartile map will collectively depict the indicators.

3. Analysis

Quartile maps showing each of the eleven health status indicators and a brief analysis will follow.

a. Lung Cancer

Cancer ranks second in leading causes of death in Montana. The median age of death due to this cause in 1976 was 69 years. Deaths from cancer of the bronchus, trachea, and lung have increased fairly steadily in recent years. Among men dying of cancer during 1976 more have cancer in this site category (28.8%) than in any other. Only 11.4% of women dying of cancer were in this category, but this is a 137.5% increase since 1968.[1]

Of the 1,191 deaths due to malignant carcinoma in 1976, 142 deaths in Silver Bow County and 47 deaths in Deer Lodge County (15.8% of the total cancer deaths) were attributed to lung cancer. According to the World Health Organization, "Smoking-related diseases are such important causes of disability and premature death in developed countries that the control of cigarette smoking could do more to improve health and prolong life in these countries than any single action in the whole field of preventive medicine."

Montana ranked 26th in the U.S. for per capita consumption of cigarettes for persons 18 years and older in 1976.[2] In fact, per capita consumption has risen 3.6 percent since 1975. Montana's per capita consumption is slightly less than the national average of 3,826 cigarettes.

Montana ranked third in the nation for death rate per 100,000 population from lung disease in 1973. The top five states were:[3]

..Wyoming	36.0
..Arizona	31.5
..Montana	29.0
..West Virginia	28.9
..Oregon	28.2

Issues Raised

Can the cause be work related, i.e., air pollution, or can it be related to the life style of miners and smelter workers, or what causative agent can be working in this area?

Why does Montana have this pocket of counties beginning in the southwestern portions of the state through central Montana ranking in the high quartile for lung cancer deaths?

Could the increase in lung cancer amongst women be reflected by smoking?

Are the individuals residing in the 14 counties ranking in the high quartile heavy smokers?

b. Uterine Cancer

There is an unusual pattern of uterine cancer when comparing it to the lung cancer pattern. Only two of the counties, Garfield and Musselshell, rank in the high quartile for both indicators.

Heavily populated counties rank in the medium low and medium high quartile while the rural counties are outranking the urban counties for the incidence of uterine cancer with rankings in the high quartile. Also, all but one Indian Reservation, Flathead (Lake County),ranks in the high quartile.

There is 29 percent of rural eastern Montana counties, Region I, ranking in the high quartile, 29 percent in the medium low/high quartile and 41 percent in the low quartile.

Urban counties, Cascade and Hill, in Region II rank in the medium low quartile while 57% of the rural counties rank in the high quartile, 14% in the medium low/high quartile, and 29 percent in the low quartile.

Urban Yellowstone County ranks in the medium low quartile in Region III, while 40 percent of the rural counties rank in the high quartile, 20 percent in the medium low/high quartile, and 40 percent in the low quartile.

Region IV had the fewest uterine cancer deaths during this period. None of the counties ranked in the high quartile. Again, the urban counties, Gallatin, Lewis & Clark, Silver Bow, and Deer Lodge ranked in the medium low/high quartile.

The urban counties of Missoula and Flathead in Region V ranked in the medium high quartile. Only one county, Sanders, ranked in the high quartile.

Issues Raised

Why do the rural counties have a higher incidence of uterine cancer than urban counties?

Do more women receive Papanicolaou tests in urban areas?

c. Infant, Neonatal, Post-Neonatal, Low Birth Weight Death Rates

The health indicator, infant mortality, is a combination of a number of different statistics, including the death rate for different aged infants, the fetal death rate, and the percent of infants born weighing less than 5½ pounds. Combined, these give an overall general picture of the health of newborn babies.

Montana's crude birth rate was 16.7 per thousand residents as compared to 14.7 per thousand in the U.S. during 1976.

The number of out-of-wedlock births are increasing in Montana. One-half of the mothers of out-of-wedlock babies were 19.6 years of age or younger.

Although the 1970 Census showed that 3.9 percent of Montana's population was Indian, 9.4 percent of all births (1,184) in 1976 were to Indian mothers. A high percentage of Indian babies were born out-of-wedlock; this may, however, misrepresent the family situation since paternity affidavits accompanying many birth certificates indicate that the parents of the child had lived together for some time.

Babies which are too small or too immature may be unable to take over the vital life functions of breathing, metabolism, excretion, and body temperature control. One in every 13 babies (7.7%) born in the United States is born too early (less than 37 weeks gestation), too small (weighing less than 5½ pounds), or both. In Montana 1,219 (10.0%) of 12,232 babies had reported gestation periods of less than 37 weeks and 824 (6.7%) of the 12,355 babies born in Montana were under 5½ pounds.

Several maternal characteristics are associated with low-birth-weight babies.[4] Low-birth-weight babies are more often born to mothers who:

..are younger than 16
..have previously given birth to a low-birth-weight baby
..are suffering from a chronic condition
..are undernourished
..smoke cigarettes
..are alcoholics
..are addicted to narcotics
..have not had regular prenatal care
..have certain genetic disorders

In Montana, one in every five low-birth-weight babies was born to a teen-aged mother; 15.45 percent (1,948) of all mothers were under 20 years of age but they gave birth to 20.62 percent (173) of the low-birth-weight babies.

Of the Indian Reservations, the Crow (Big Horn County), Fort Peck (Roosevelt County), and Blackfeet (Glacier County) rank in the high quartile rankings of infant health indicators. The Rocky Boy Reservation (Phillips and Blaine Counties), ranked in the medium low quartile while the Flathead (Lake County) ranked in the medium high quartile. Even so, the Indian Health Service, under the DHEW, has made dramatic improvements since approximately 1963, when it was under the Bureau of Indian Affairs.

Region IV is higher in all indicators than the other Regions with 50 percent of the counties ranking in the high quartile, 25 percent in the medium low/high, and 25 percent in the low quartile (all rural counties).

Region I ranked the most favorable with 88.2 percent of the counties ranking in the low and medium low/high quartile with only 11.8 percent of the counties ranking in the high quartile.

Region III has 45.5 percent of the counties ranking in the low quartile, 27.3 percent ranking in the medium low/high, and 27.3 percent in the high quartile.

Region V is consistent with 85.7 percent of the counties ranking in the medium low/high quartile.

Region II has 11 percent of the counties ranking in the low quartile, 66 percent in the medium low/high, and 22 percent in the high quartile.

The following Table compares the above indicators to the United States during 1976 (per 1,000 births).

	Montana	U.S.
Infant Mortality	13.8	14.0
Neonatal Mortality	8.9	9.9
Postneonatal Mortality	4.8	4.2
Low-weight-birth rates (5 lb. 8 oz. or less)	10.0	7.7

Issues Raised

Is there some causative agent working in Region IV that might be altitude, ethnic origin of mothers, air pollution, water pollution or life style (smoking, drinking, etc.)?

If the health of newborns reflects fairly directly the health of mothers, what are the implications to the population at large?

d. Cirrhosis of the Liver

In 1976, for the first time, cirrhosis of the liver was among Montana's 10 most frequent causes of death -- ranking ninth. If all natural causes mentioning alcoholism are added to all cirrhosis deaths, the rank would be seventh among 1976 deaths.

Most cirrhosis deaths (64.7%) occurred among males. Although only 4.2 percent of all Montana deaths were Indians, 20.2 percent of all cirrhosis deaths were Indians.

The median age at death due to alcoholic cirrhosis is consistently younger than that due to cirrhosis without mention of alcoholism.

Too, cirrhosis of the liver may not be mentioned on death certificates. Often, death is primarily caused from cirrhosis but will be reported as some other disease or accident.

Three of the six counties with Indian Reservations rank in the high quartile and three rank in the medium low quartile. Rosebud County has a high Indian population and a high migrancy rate (Colstrip) which might be conducive to the highest ranking in the state.

Silver Bow County is the only urban county ranking in the high quartile, while Yellowstone, Lewis & Clark, Deer Lodge, Cascade and Hill rank medium high, and Missoula and Flathead rank medium low. Thirteen rural counties rank in the high quartile and they are relatively equally dispersed across the state.

Issues Raised

Is there a genetic component in the Indian population causative to cirrhosis or is it life style?

Because rural counties rank so high in cirrhosis, can the cause be lack of things to do other than consume alcohol, or is it again an accepted life style?

Why do the more populated areas have relatively fewer cases of cirrhosis of the liver?

5. Suicide and Homicide

Suicide and homicide are two indicators, among others, relating to the overall mental health of a population.

During 1976 there were 129 suicides in Montana for a cause specific rate of 17.1 per hundred thousand population. In 1977 there were 141 suicides for a 9 percent increase over 1976 (using the 1977 population estimate of 761,000) and a cause specific rate of 18.5 per hundred thousand population. This is well above the national cause specific rate of 12.5 for 1977.[5]

Suicide ranked third as cause of death in the 15-24 and 25-34 age groups during 1976. It was only surpassed by motor vehicle accidents and accidents exclusive of motor vehicle. It is impossible to project how many accidents might have been actually suicide. For the 35-44 year age group, suicide ranked fifth as the cause of death.

It is commonly thought that a higher percentage of Indians than whites commit suicide. In 1976, 1.9 percent of all deaths were categorized as suicide, while 2.5 percent of Indian deaths were classed as purposely self-inflicted.

Even though the population in Montana is increasing, the homicide rate decreased overall from 1973-1977--the reverse of the suicide rate.

Montana Homicide Incidence[6] (per 100,000 population)

1973	Rate	1974	Rate	1975	Rate	1976	Rate	1977	Rate
48	6.7	44	6.0	46	6.2	41	5.4	40	5.3

The national homicide rate for 1976 was 8.8, substantially more than Montana's rate.

Approximately 7.7 percent of felony arrests against persons were females, while 12.7 percent were juveniles during 1977. Indians comprised 25 percent of the total arrests against persons.

Cascade County ranked as the most violent area in the state for 1976 with a crude rate of 6.0. High-crime areas correspond to high population areas of the state. The opposite is true with suicide as the only highly populated area with a high incidence of suicide was Lewis & Clark County in the same time period.

For both the suicide and homicide indicators, fourteen Montana counties, or 25 percent, ranked in the high quartile for suicide and homicide death rates. All but one of the counties would be rated rural.

Of the nine urban counties, Gallatin ranked in the low quartile; Deer Lodge, Missoula, and Yellowstone ranked medium low; Cascade, Flathead, Hill and Silver Bow ranked medium high; and Lewis & Clark ranked in the high quartile.

Issues Raised

What factors are conducive to suicide among the age groups 15-24 and 25-34?

Why are rural counties higher in suicide incidence than urban?

Is there need for more comprehensive mental health services for children?

Should suicide prevention programs be expanded?

Is the needs assessment adequate for high suicide areas?

Could mental health education help prevent suicide and crime against persons?

6. Motor Vehicle Accidents and Accidents Other Than Motor Vehicle

Motor vehicle accidents caused 50.3 percent of all accidental deaths, and the median age at death was 26.5 years. The crude death rate due to motor vehicle accidents has decreased from a high of 50.1 per 100,000 population in 1972 to 38.6 per 100,000 in 1976, which possibly reflects reduced speed limits.

Accidents other than motor vehicle strike the relatively young. Median age of persons dying due to accidents was 30.9 years in 1976. Accidents accounted for 57.4 percent of deaths in the 1-4 year age group and 66 percent of deaths in the 5-14 year age group. Important industries in Montana are lumber, agriculture and mining, and occupationally are quite dangerous, thus causing many accidental deaths.

Accidents relate to the emergency medical services system. It is notable that all urban areas, with the exception of Deer Lodge and Silver Bow Counties, rank in the low or medium low quartile and most urban areas have emergency medical services.

Regional Ranks 1972-1976

	Motor Vehicle Accident Death Rates Ranks	Other Accident Death Rate Ranks
Region I	2	5
Region II	1	2
Region III	5	4
Region IV	4	3
Region V	3	1

Because accidents are the leading cause of death for persons 1-45 years of age, perhaps more programs should be implemented. Health and safety education programs could be instrumental for saving some lives or preventing some injuries. By spending more time and effort on educational and safety programs, less time and effort will need to be spent on ambulances and emergency rooms and ultimately, on long-term care for the permanently disabled.

Five out of seven Indian Reservation counties rank in the high quartile for motor vehicle related deaths.

Issues Raised

Do rural areas need more comprehensive emergency medical services?

Is manpower an issue in rural counties to alleviate accidental deaths?

Do health and safety education programs need to be implemented?

7. Age-Adjusted Death Rates

Age-adjusted death rates are what the death rate would have been if all counties in the state would have had the same age distribution.

Only one Indian Reservation was in the low quartile, while five of seven were in the high quartile.

Most of the populated counties rank in the low or medium low quartile.

This indicator compares to the aforementioned indicators.

8. Health Status Indicator Ranks

This indicator is a summary of all the aforementioned indicators. An analysis of the health status indicator ranks yields some interesting results. The five counties with the best overall record are Wibaux, Stillwater, Judith Basin, Dawson and Carter--three of which are in Region I where few ancillary health care services are accessible without traveling to larger counties.

Several possible explanations for this apparent inconsistency exist. First, persons in these counties are probably obtaining health care services in other areas. Second, a possible explanation is that of small population. A county with a small population can have low rates for all selected indicators from zero if there were no deaths, or a relatively high rate if there was even one death among the indicators.

The quartile maps following the narrative of this section were aids in the geographic and population-based analysis of health status rankings which will be expanded in phase II of the Preliminary State Health Plan. Note that there are several rural counties, mostly in eastern and central Montana, in the low quartile. Only one county, Missoula, is in the low quartile west of the Continental Divide. Gallatin and Missoula are the only counties with over 15,000 population in the low health status quartile, while Yellowstone and Hill counties ranked in the medium low quartile.

Counties of 15,000 or more population in the high quartile are: Silver Bow, Deer Lodge and Lake counties. Several counties with substantial Indian populations are also in the high quartile; namely, Big Horn, Glacier, Roosevelt, Lake and Rosebud.

The healtn status indicators describe conditions which can promote needed changes in the health care system, public health, and mental health.

*INDICATORS INCLUDE AGE ADJUSTED DEATH RATES WHICH ARE BASED ON 1969-71 DATA.
SOURCE: BUREAU OF RECORDS AND STATISTICS AND BUREAU OF THE CENSUS.

----	1 - 14	LOW QUARTILE
****	15 - 28	MEDIUM LOW QUARTILE
****	29 - 42	MEDIUM HIGH QUARTILE
****	43 - 56	HIGH QUARTILE

FIVE-YEAR DEATH RATES FOR CANCER OF THE LUNG: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS PER 100,000 ESTIMATED POPULATION.
EIGHTH REVISION ICDA RUBRIC 1621.
SOURCE: BUREAU OF RECORDS AND STATISTICS
AND BUREAU OF THE CENSUS.

----	0.0 - 24.6	LOW QUARTILE
****	24.9 - 30.7	MEDIUM LOW QUARTILE
****	31.4 - 40.5	MEDIUM HIGH QUARTILE
****	40.9 - 90.9	HIGH QUARTILE

FIVE-YEAR DEATH RATES FOR CANCER OF THE UTERUS: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS PER 100,000 ESTIMATED POPULATION.
EIGHTH REVISION ICDA RUBRICS 180-182.
SOURCE: BUREAU OF RECORDS AND STATISTICS
AND BUREAU OF THE CENSUS.

----	0.0 - 0.0	LOW QUARTILE
****	1.1 - 3.7	MEDIUM LOW QUARTILE
****	3.8 - 7.2	MEDIUM HIGH QUARTILE
****	7.4 - 17.1	HIGH QUARTILE

FIVE-YEAR FETAL MORTALITY RATIOS: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

FETAL DEATHS OF GESTATION PERIOD 20 WEEKS AND OVER PER 1,000 LIVE BIRTHS.
SOURCE: BUREAU OF RECORDS AND STATISTICS.

----	0.0 - 5.3	LOW QUARTILE
****	5.6 - 8.2	MEDIUM LOW QUARTILE
****	8.4 - 12.5	MEDIUM HIGH QUARTILE
****	12.6 - 33.3	HIGH QUARTILE

FIVE-YEAR INFANT MORTALITY RATES: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS AT AGE LESS THAN 1 YEAR PER 1,000 LIVE BIRTHS.
SOURCE: STATE DEPT OF HEALTH AND ENVIRONMENTAL SCIENCES.

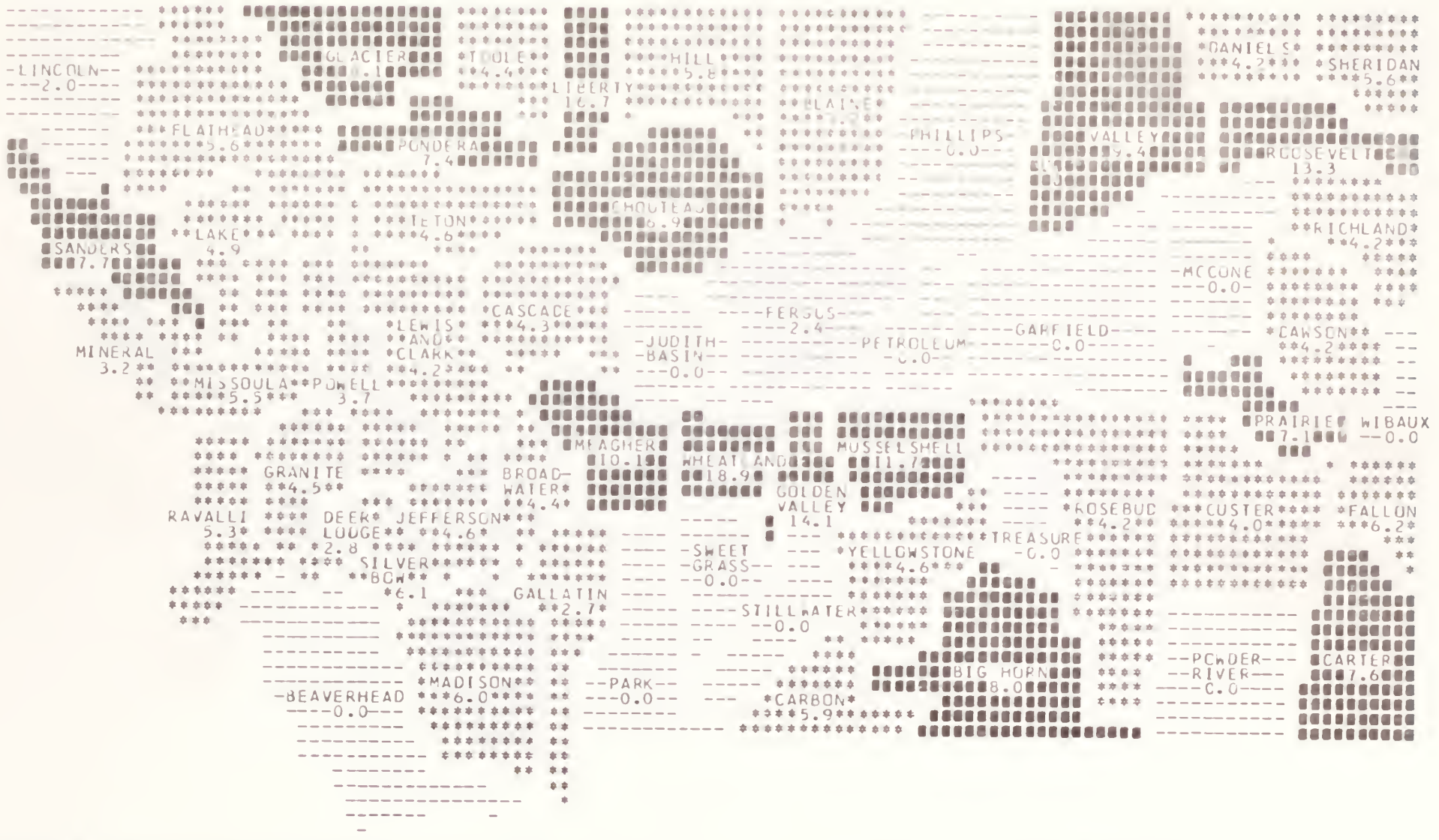
----	0.0 - 10.9	LOW QUARTILE
****	11.2 - 16.0	MEDIUM LOW QUARTILE
****	16.2 - 20.2	MEDIUM HIGH QUARTILE
****	24.6 - 45.2	HIGH QUARTILE

FIVE-YEAR NEONATAL MORTALITY RATES: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS AT AGE LESS THAN 28 DAYS PER 1,000 LIVE BIRTHS.
SOURCE: BUREAU OF RECORDS AND STATISTICS.

----	0.0 - 7.5	LOW QUARTILE
****	7.6 - 11.7	MEDIUM LOW QUARTILE
****	11.9 - 16.1	MEDIUM HIGH QUARTILE
****	16.2 - 35.2	HIGH QUARTILE

FIVE-YEAR POST NEONATAL MORTALITY RATES: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)



DEATHS AT AGES 28-364 DAYS PER 1,000 LIVE BIRTHS.
SOURCE: BUREAU OF RECORDS AND STATISTICS.

----	0.0 - 2.4	LOW QUARTILE
****	2.7 - 4.4	MEDIUM LOW QUARTILE
****	4.5 - 6.2	MEDIUM HIGH QUARTILE
****	6.9 - 18.9	HIGH QUARTILE

FIVE-YEAR LOW-BIRTH-WEIGHT RATES: MONTANA COUNTIES, 1972-76
(BY PLACE OF RESIDENCE)

INFANTS WITH BIRTH WEIGHT UNDER 5 POUNDS 9 OUNCES PER 1,000 LIVE BIRTHS.
SOURCE: STATE DEPT OF HEALTH AND ENVIRONMENTAL SCIENCES.

----	17.2 - 53.9	LOW QUARTILE
****	56.0 - 68.0	MEDIUM LOW QUARTILE
****	68.4 - 78.6	MEDIUM HIGH QUARTILE
****	78.7 - 120.8	HIGH QUARTILE

FIVE-YEAR DEATH RATES FOR CIRRHOSIS OF THE LIVER: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS PER 100,000 ESTIMATED POPULATION.
EIGHTH REVISION ICDA RUBRIC 571.
SOURCE: BUREAU OF RECORDS AND STATISTICS
AND BUREAU OF THE CENSUS.

----	0.0 - 5.8	LOW QUARTILE
****	6.4 - 11.6	MEDIUM LOW QUARTILE
****	12.3 - 17.0	MEDIUM HIGH QUARTILE
****	18.0 - 43.5	HIGH QUARTILE

FIVE-YEAR DEATH RATES FOR SUICIDE AND HOMICIDE: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS PER 100,000 ESTIMATED POPULATION.
EIGHTH REVISION ICDA RUBRICS 950-970.
SOURCE: BUREAU OF RECORDS AND STATISTICS
AND BUREAU OF THE CENSUS.

----	0.0 - 14.2	LOW QUARTILE
****	14.5 - 19.3	MEDIUM LOW QUARTILE
****	19.4 - 23.0	MEDIUM HIGH QUARTILE
****	23.9 - 59.8	HIGH QUARTILE

FIVE-YEAR DEATH RATES FOR MOTOR VEHICLE ACCIDENTS: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS PER 100,000 ESTIMATED POPULATION.
EIGHTH REVISION ICDA RUBRICS 810-823.
SOURCE: BUREAU OF RECORDS AND STATISTICS
AND BUREAU OF THE CENSUS.

----	10.8 - 35.3	LOW QUARTILE
****	35.4 - 45.4	MEDIUM LOW QUARTILE
****	46.3 - 66.2	MEDIUM HIGH QUARTILE
****	66.7 - 96.1	HIGH QUARTILE

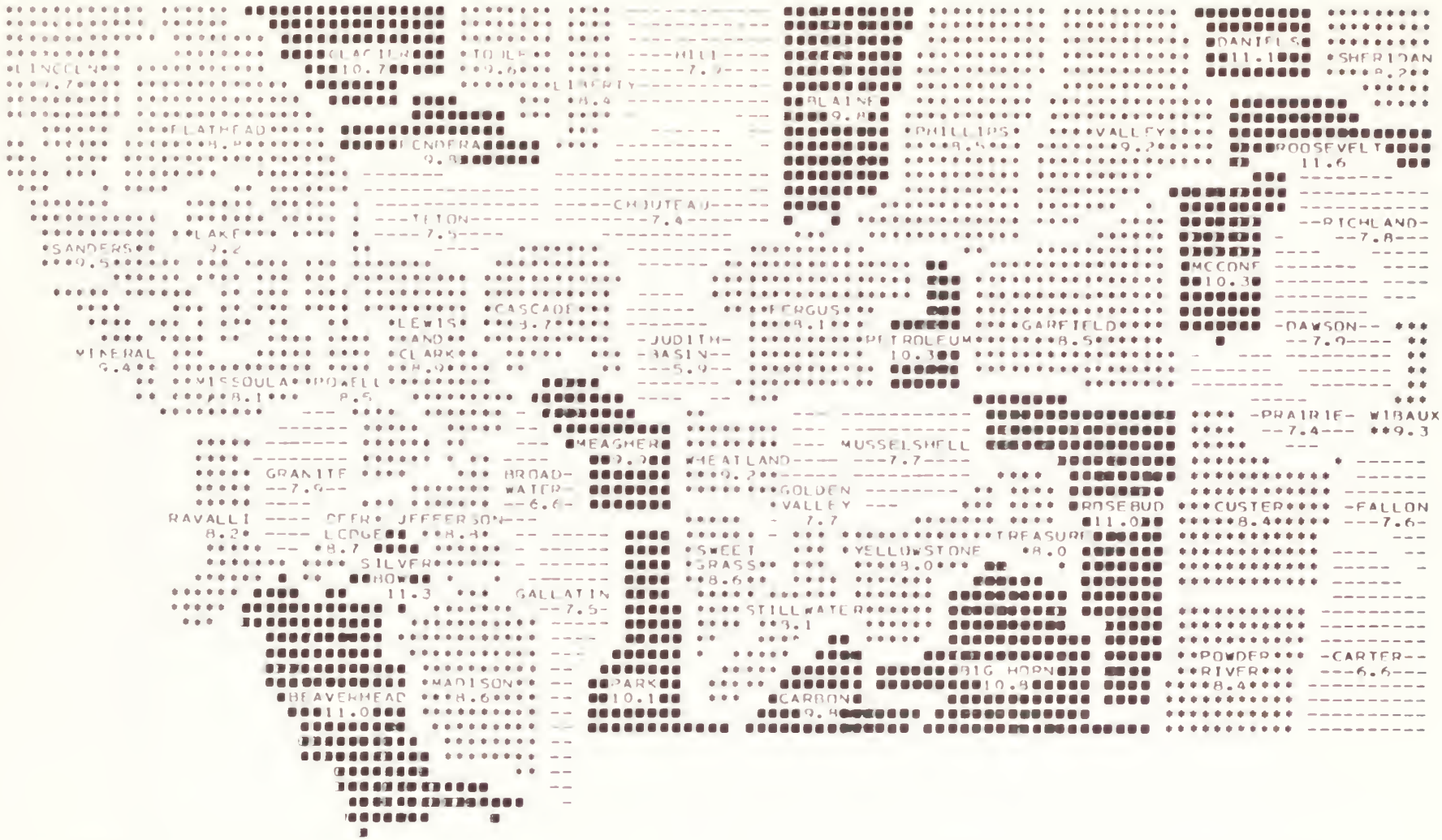
FIVE-YEAR DEATH RATES FOR ACCIDENTS OTHER THAN MOTOR VEHICLE: MONTANA COUNTIES, 1972-1976
(BY PLACE OF RESIDENCE)

DEATHS PER 100,000 ESTIMATED POPULATION.
EIGHTH REVISION ICDA RUBRICS 800-807, 825-949.
SOURCE: BUREAU OF RECORDS AND STATISTICS
AND BUREAU OF THE CENSUS.

----	0.0 - 30.7	LOW QUARTILE
****	32.1 - 41.6	MEDIUM LOW QUARTILE
****	42.1 - 51.2	MEDIUM HIGH QUARTILE
****	52.2 -112.8	HIGH QUARTILE

AGE-ADJUSTED DEATH RATES - MONTANA COUNTIES, 1962-71

BY PLACE OF RESIDENCE



DEATHS PER 1,000 POPULATION.

----	5.9 - 7.9	LOW QUARTILE
****	8.0 - 8.6	MEDIUM LOW QUARTILE
****	8.7 - 9.7	MEDIUM HIGH QUARTILE
****	9.8 - 11.6	HIGH QUARTILE

B. Geographic Characteristics

The following section will provide an overview of the state topography and transportation system.

1. Topographical Characteristics

As the fourth largest state, Montana covers 147,138 square miles with distances averaging 550 miles in length to 275 miles in width. The topography varies from mountain crests characteristic of the western third of the state, to the elevated plains, low mountains, and erosion valleys in the central portion, to the flat terrain in eastern Montana as displayed in Exhibit 1.

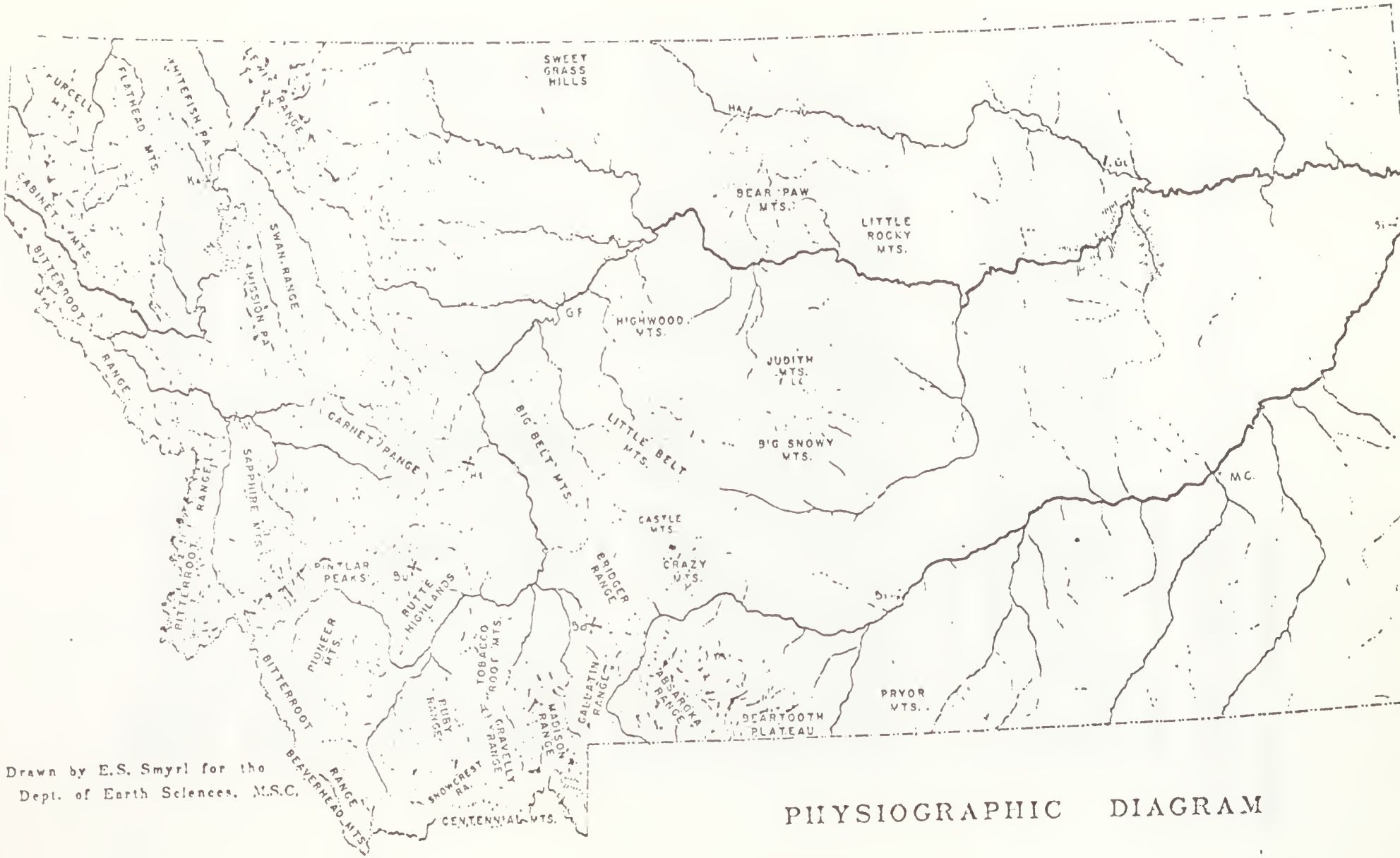
2. Transportation Systems

The transportation system in Montana, in conjunction with severe weather conditions and number of miles to travel, is a key factor in determining accessibility to health care services. Since Montana's tertiary health care facilities are located in three major cities, Missoula, Great Falls, and Billings, and secondary care facilities are located in Kalispell, Butte, Helena, and Bozeman in addition to the aforementioned, the demands on the transportation system are extreme. Scheduled public transportation systems are almost non-existent in rural areas. Ambulance, volunteer transportation, and private automobiles are the main public systems outside metropolitan areas. Transportation limitations greatly affect access to health care resources other than primary health care.

Much of the state is relatively isolated from major urban centers. These areas are sparsely populated and difficult to serve with adequate health care resources. In Montana, county and private roads equal or exceed the improved highways in terms of actual miles. In addition, most roads follow the topography and thus many are hilly and curvy, thus lengthening travel time and making it more difficult and dangerous. Highway density is the lowest in north central and southeastern Montana (see exhibit 2). Also, many roads and highways are closed intermittently during heavy snowfall and blizzard conditions.

Montana's railroad network primarily serves east-west transcontinental traffic, but not on a daily basis. Air travel is restrictive to Montana residents living outside urban areas and even to those living in urban areas during the winter months.

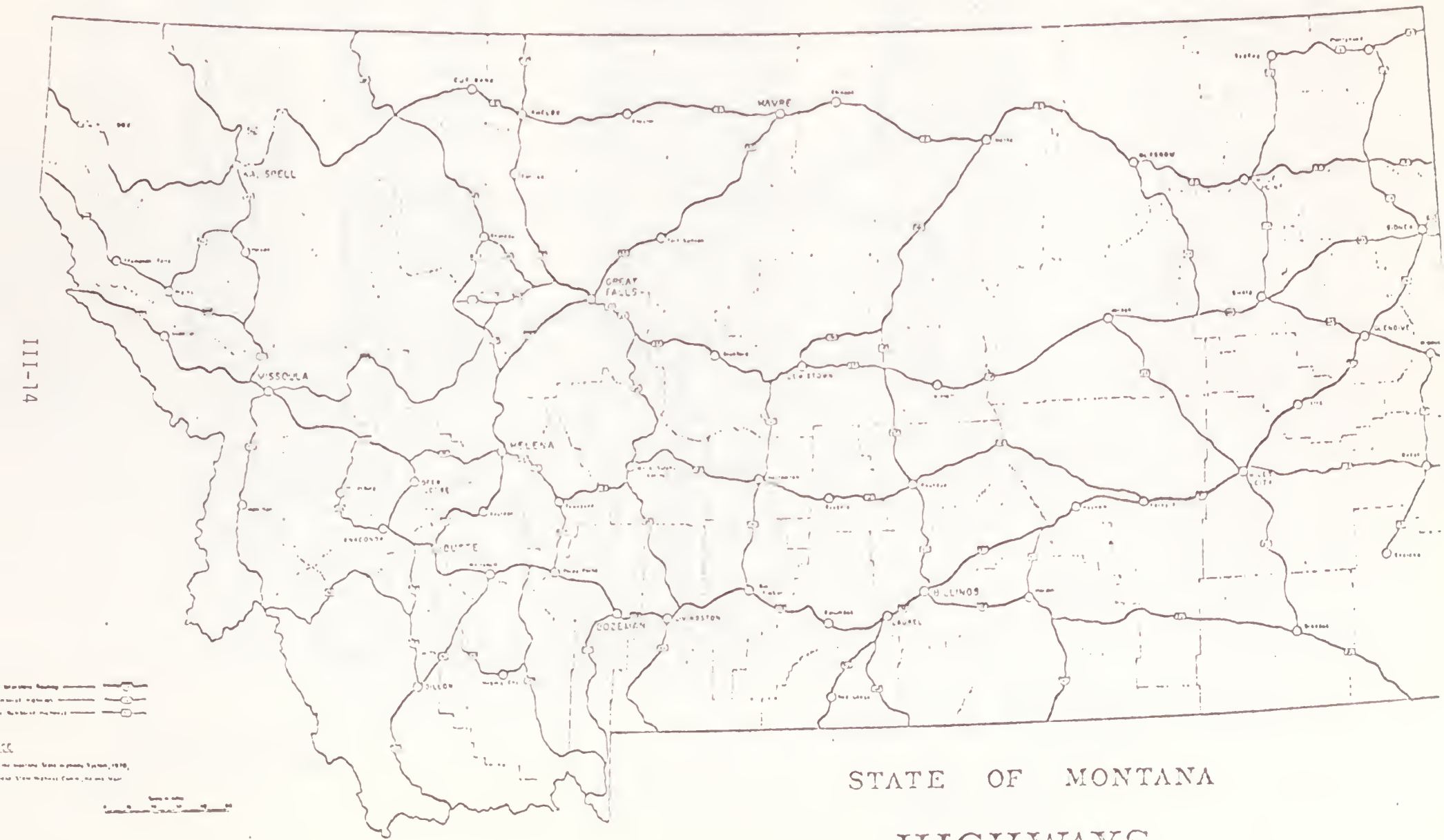
Utilization of health services are affected by Montana's transportation systems and travel restrictions imposed by natural causes. These conditions also affect health service delivery patterns.



Drawn by E.S. Smyrl for the
Dept. of Earth Sciences, M.S.C.

PHYSIOGRAPHIC DIAGRAM

Exhibit 2



STATE OF MONTANA

HIGHWAYS

C. Political Subdivisions (Planning and Administrative Regions and Subareas)

There are 56 counties in Montana. On August 24, 1971 a Governor's Executive Order established 12 multi-county districts for use in planning and administration. This was amended on October 29, 1973 by Governor's Executive Order 7-73 which directed all state agencies that could most productively serve the state with fewer than 12 districts to adopt five administrative regions (subareas) as displayed in Exhibit 3.

D. Demographic Characteristics

1. Rural/Urban Characteristics

Montana is sparsely populated with a total of 761,000 residents.[7] Table 6 presents the current and projected population estimate for each of the 56 counties. In 1970, 47 percent of the residents were classified as living in rural areas, with only two of the state's cities, Billings located in Yellowstone County and Great Falls located in Cascade County, qualifying as "Standard Metropolitan Statistical Areas".

2. Age Distribution

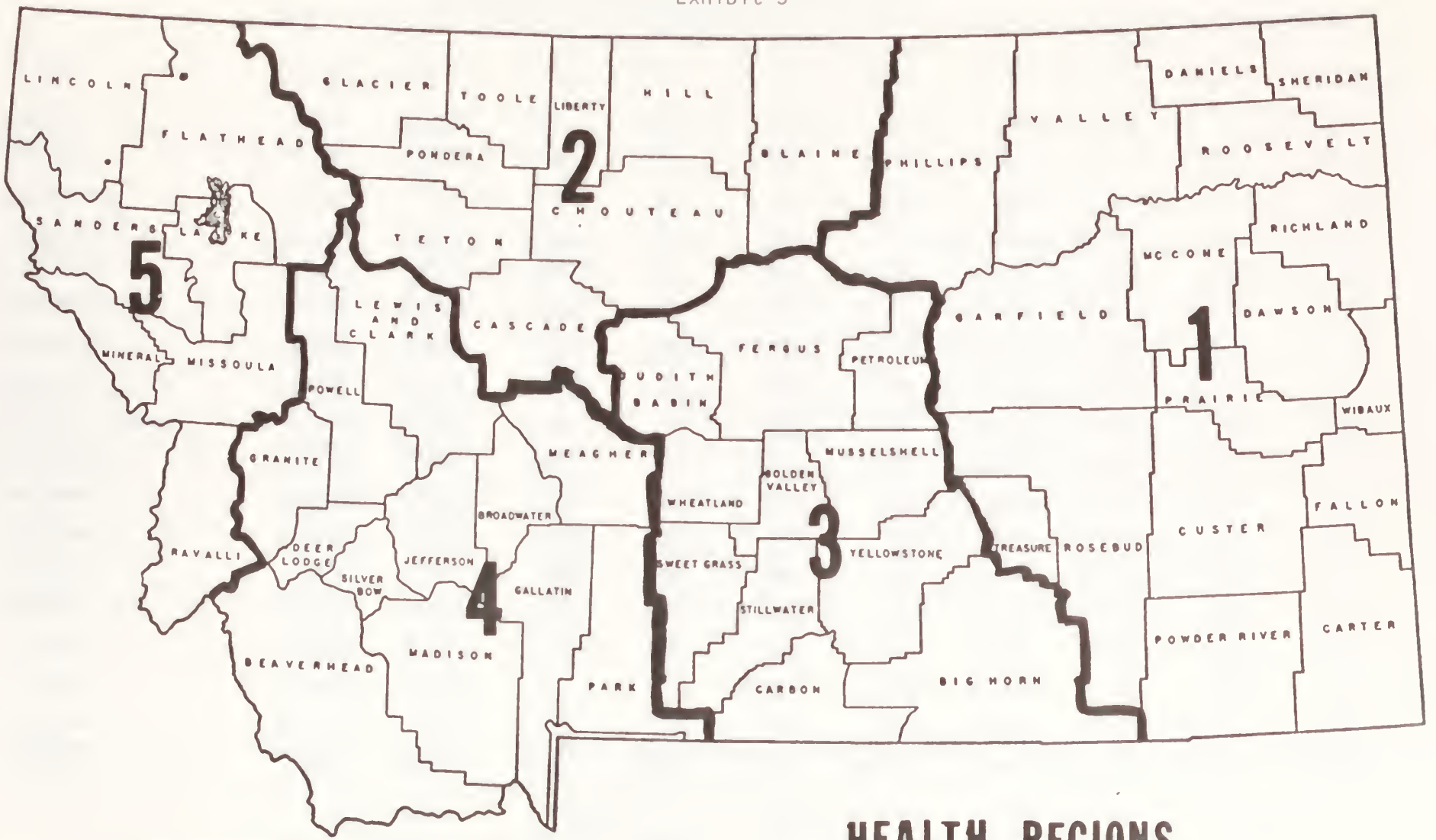
It is well documented that different age groups use different health services. For example, children under five years could be the target of immunizations, females in the childbearing years (generally between the ages of 15-44) could be the target of managed health care during the prenatal period, males between 45-64 are the most prone to heart attacks, and the elderly (over 65 years of age) are the primary users of long-term care facilities and home health services. Tables one through five show the estimated 1975 and projected 1985 population for four age groups by county and region.

3. Population Trends

Montana's population is increasing. From 1971-1976, the overall increase was 43,000, a statewide increase of 9.4 percent.[8] The rate of increase varies considerably by county with some counties experiencing overall decreases in population. Table 6 depicts the current and projected population by county.
The state average for net migration during the period 1960-1970 was 58,153 or 8.6 percent.[9] The increase was basically noted into/around major Montana cities.

Data indicate changes in age group size between 1960-1970. In the youngest age group (under 5), the population decreased from 83,102 in 1960 to 57,054 in 1970 or 6.9 percent.[10] The age group 5-17, 18-59, 60-64 and 65+ show increases ranging from 8 percent to 9.5 percent with the largest increase in the 65+ age group.

Exhibit 3



No. 1050 — County Outline Map
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HEALTH REGIONS
in
MONTANA

1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP AND COUNTY

EASTERN MONTANA (Region I)

Table 1

	TOTAL POP.		AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Carter	1,900	1,882	137	142	433	361	1,059	1,120	271	259
Custer	12,000	14,642	917	1,212	2,992	3,006	6,593	8,625	1,498	1,799
Daniels	3,100	3,143	214	259	729	600	1,699	1,808	458	476
Dawson	10,700	13,067	937	1,156	2,822	2,757	5,954	7,868	987	1,286
Fallon	4,000	4,326	342	390	1,049	915	2,206	2,549	403	472
Garfield	1,700	1,784	140	139	410	352	982	1,072	168	221
McCone	2,700	2,613	211	201	710	532	1,488	1,552	291	328
Phillips	5,400	5,757	435	471	1,417	1,243	2,830	3,302	718	741
Powder River	2,400	2,285	207	174	666	499	1,331	1,406	196	206
Prairie	1,900	1,915	123	140	408	352	1,077	1,092	292	331
Richland	9,900	12,093	797	998	2,596	2,585	5,407	7,094	1,110	1,416
Roosevelt	10,300	11,272	1,013	1,005	2,883	2,711	5,399	6,412	1,005	1,144
Rosebud	9,700	11,230	943	931	2,680	2,809	5,168	6,531	909	959
Sheridan	5,400	5,144	371	382	1,383	1,011	2,931	2,946	715	805
Treasure	1,200	1,236	94	105	318	272	653	721	135	138
Valley	13,200	16,325	1,160	1,391	3,700	3,935	7,297	9,858	1,043	1,141
Wibaux	1,500	1,538	121	135	386	319	806	892	187	192
TOTALS	97,000	110,252	8,162	9,231	25,582	24,259	52,880	64,848	10,386	11,914

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, Aug. 1977 (Medium Series)

1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP AND COUNTY

NORTH CENTRAL MONTANA (Region II)

Table 2

	TOTAL POP.		AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Blaine	6,800	7,191	617	631	1,827	1,639	3,603	4,191	753	730
Cascade	83,900	88,274	7,668	8,195	21,061	19,503	47,921	52,875	7,250	7,701
Chouteau	6,300	6,491	496	551	1,540	1,314	3,503	3,845	761	781
Glacier	11,100	11,961	1,188	1,041	3,361	3,142	5,635	6,631	916	1,147
Hill	17,900	19,641	1,552	1,694	4,392	4,046	10,389	11,960	1,567	1,941
Liberty	2,500	2,697	190	228	671	562	1,421	1,636	218	271
Pondera	6,900	7,462	583	647	1,868	1,673	3,718	4,329	731	813
Teton	6,500	7,875	458	610	1,659	1,710	3,582	4,621	801	934
Toole	5,400	5,174	398	412	1,416	1,079	2,994	3,048	592	635
TOTALS	147,300	156,766	13,150	14,009	37,795	34,668	82,766	93,136	13,589	14,953

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, Aug. 1977 (Medium Series)

1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY

SOUTH CENTRAL MONTANA (Region III)

Table 3

	TOTAL POP.		AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Big Horn	10,900	12,161	1,221	1,055	3,138	3,162	5,780	7,053	761	891
Carbon	7,800	8,889	495	672	1,734	1,796	4,213	5,010	1,358	1,411
Fergus	13,000	13,617	927	1,040	3,232	2,705	6,892	7,811	1,949	2,061
Golden Valley	900	917	59	70	188	160	510	534	143	153
Judith Basin	2,700	2,745	193	233	646	531	1,445	1,530	416	451
Musselshell	4,200	4,796	297	373	963	1,008	2,292	2,761	648	654
Petroleum	700	678	48	50	178	144	425	435	49	49
Stillwater	5,200	6,090	351	472	1,231	1,290	2,874	3,533	744	795
Sweet Grass	3,000	2,897	210	221	630	540	1,628	1,657	532	479
Wheatland	2,400	1,923	165	126	557	347	1,309	1,096	369	354
Yellowstone	97,000	126,106	7,936	10,456	24,383	28,134	56,961	76,914	8,020	10,602
TOTALS	148,100	180,819	11,902	14,768	36,880	39,817	111,697	108,334	14,989	17,900

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, Aug. 1977 (Medium Series)

1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY

SOUTHWESTERN MONTANA (Region IV)

Table 4

	TOTAL POP.		AGE 0 - 4		AGE 5 - 17		Age 18 - 64		AGE 65 +	
COUNTY	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Beaverhead	8,300	9,095	699	868	1,849	1,798	4,862	5,485	890	944
Broadwater	2,800	3,428	206	287	732	771	1,524	2,002	338	368
Deer Lodge	15,200	15,482	1,144	1,245	3,482	2,991	8,630	9,071	1,944	2,175
Gallatin	37,300	44,058	2,851	3,527	7,128	7,342	24,304	29,510	3,017	3,679
Granite	2,700	2,801	206	236	638	564	1,528	1,600	328	401
Jefferson	6,700	8,169	539	684	1,724	1,869	3,844	4,948	593	668
Lewis & Clark	36,900	46,931	3,008	3,865	9,247	10,526	21,020	28,090	3,625	4,450
Madison	5,800	5,556	396	422	1,367	1,072	3,163	3,223	874	839
Meagher	2,300	2,216	174	173	527	429	1,327	1,326	272	288
Park	12,100	14,590	839	1,143	2,778	3,088	6,768	8,472	1,715	1,887
Powell	7,500	9,015	568	729	1,865	1,983	4,373	5,571	694	732
Silver Bow	43,000	44,457	3,422	3,581	10,618	9,335	23,847	26,555	5,113	4,986
TOTALS	180,600	205,798	14,052	16,760	41,955	41,768	105,190	125,853	19,403	21,417

SOURCE: Montana Population Projections 1975 - 2000 Division of Research & Information Systems, Montana Department of Community Affairs, Aug. 1977 (Medium Series)

Table 5
1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY
NORTHWESTERN MONTANA (Region V)

	TOTAL POP.		AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Flathead	44,600	56,402	3,611	4,679	11,754	12,791	24,640	33,309	4,595	5,623
Lake	17,100	19,876	1,425	1,603	4,434	4,551	8,906	11,210	2,335	2,512
Lincoln	16,500	16,589	1,433	1,285	4,587	3,634	9,334	10,108	1,146	1,562
Mineral	3,500	4,325	295	373	972	1,036	1,967	2,610	266	306
Missoula	64,600	78,171	5,106	6,240	14,317	14,404	40,199	51,370	4,978	6,157
Ravalli	18,400	21,142	1,321	1,630	4,532	4,483	9,728	11,886	2,828	3,143
Sanders	8,100	9,588	615	750	2,061	2,141	4,350	5,539	1,074	1,158
TOTALS	172,800	206,093	13,806	16,560	42,648	43,040	99,124	126,032	17,222	20,461

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, Aug. 1977 (Medium Series)

MONTANA

Current and Projected Population by County
Table 6

	1970	1975	1980	1985	1990
Region I					
Carter	1,956	1,900	1,853	1,882	1,899
Custer	12,174	12,000	13,524	14,642	15,515
Daniels	3,083	3,100	3,023	3,143	3,206
Dawson	11,269	10,700	11,881	13,067	13,994
Fallen	4,050	4,000	4,048	4,326	4,539
Garfield	1,796	1,700	1,689	1,784	1,861
McCone	2,875	2,700	2,530	2,613	2,678
Phillips	5,386	5,400	5,501	5,757	5,978
Powder River	2,862	2,400	2,203	2,285	2,370
Prairie	1,752	1,900	1,895	1,915	1,917
Richland	9,837	9,900	11,186	12,093	12,815
Roosevelt	10,365	10,300	10,761	11,272	11,958
Rosebud	6,032	9,700	10,870	11,230	11,521
Sheridan	5,779	5,400	5,019	5,144	5,242
Treasure	1,069	1,200	1,199	1,236	1,254
Valley	11,471	13,200	14,433	16,325	18,175
Wibaux	1,465	1,500	1,474	1,538	1,577
Region II					
Blaine	6,727	6,800	6,939	7,191	7,506
Cascade	81,804	83,900	85,112	88,112	90,658
Chouteau	6,473	6,300	6,266	6,491	6,627
Glacier	10,783	11,100	11,514	11,961	12,807
Hill	17,358	17,900	18,421	19,641	20,769
Liberty	2,359	2,500	2,561	2,697	2,798
Pondera	6,611	6,900	7,106	7,462	7,790
Teton	6,116	6,500	6,979	7,875	8,734
Toole	5,839	5,400	5,042	5,174	5,271
Region III					
Big Horn	10,057	10,900	11,716	12,161	12,976
Carbon	7,080	7,800	8,112	8,889	9,558
Fergus	12,611	13,000	13,112	13,617	14,001
Golden Valley	931	900	879	917	936
Judith Basin	2,667	2,700	2,631	2,745	2,796
Musselshell	3,734	4,200	4,367	4,796	5,165
Petroleum	675	700	679	678	675
Stillwater	4,632	5,200	5,486	6,090	6,627
Sweet Grass	2,980	3,000	2,907	2,897	2,851
Wheatland	2,529	2,400	1,977	1,923	1,869
Yellowstone	87,367	97,300	109,073	126,106	142,340
Region IV					
Beaverhead	8,187	8,300	8,703	9,095	9,375
Broadwater	2,526	2,800	3,011	3,428	3,822
Deer Lodge	15,652	15,200	14,839	15,482	15,942
Gallatin	32,505	37,300	40,501	44,058	47,158
Granite	2,737	2,700	2,656	2,801	2,907
Jefferson	5,238	6,700	7,269	8,169	8,945
Lewis & Clark	33,281	36,900	40,930	46,931	52,691
Madison	5,014	5,800	5,602	5,556	5,455
Meagher	2,122	2,300	2,198	2,216	2,224
Park	11,197	12,100	12,991	14,590	16,075
Powell	6,660	7,500	8,030	9,015	9,921
Silver Bow	41,981	43,000	43,110	44,457	45,476
Region V					
Flathead	39,460	44,600	49,095	56,402	63,305
Lake	14,445	17,100	18,212	19,876	21,562
Lincoln	18,063	16,500	15,874	16,589	17,287
Mineral	2,958	3,500	3,809	4,325	4,808
Missoula	58,263	64,600	71,248	78,171	84,727
Ravalli	14,409	18,400	19,331	21,142	22,649
Sanders	7,093	8,100	8,653	9,588	10,494

4. Sex Ratio

The sex ratio is the number of males per 100 families. The male/female ratio has shifted from an excess of males in 1960 to slightly more females in 1970. Montana has reflected the same general trend as the nation, but not to as great an extent, with only .9 percent differentiation between the male/female ratio. The above statistics are depicted in Table 7.

5. Median Age

The median age of females increased from 27.1 years in 1960 to 27.6 years in 1970, while the median age of males decreased from 28.0 years in 1960 to 26.6 years in 1970.

6. Education

Lastly, the trend toward median school years attained by the Montana populace has increased from 11.6 in 1960 to 12.3 in 1970.

7. Native Americans

Native Americans constitute the state's major minority group at 4 percent of the total population.[11] Estimates of the number of Native Americans are presented in Table 8. There are 7 Indian Reservations in Montana as displayed in Exhibit 4.

E. Socio-Economic Characteristics

1. Income/Poverty

Family income varies greatly from county to county. The average income is high in the northcentral region which might be attributed to the thousands of acres of wheat land along the hi-line. There are more counties in eastern Montana with families who have incomes below the poverty level[12] even though the per capita personal income averages $6,126.[13] Petroleum County has the lowest per capita personal income while Chouteau County has the highest.

2. Employment/Unemployment

Data received from the Department of Labor and Industry for 1977 indicates that the Montana civilian labor force consisted of 343,000 persons. The unemployment of 22,000 was reflected as an average unemployment rate of 6.4 percent. This compares to the nation's unemployment rate of 7.0 percent. Unpublished data for August, 1978 indicate that this trend will continue as there were 391,000 persons in the civilian labor force with 20,800 unemployed. This reflects an average unemployment rate of 5.3 percent compared to the nation's unemployment rate of 6.3 percent.

Table 7

MONTANA

Population by Age and Sex

Female	1960	1970
Under 5	40,918	27,934
5 years	8,067	6,295
5-17 yrs.	87,559	96,345
18 years	4,675	6,740
18-59 yrs.	159,324	172,334
60-64 yrs.	11,449	13,850
65+ years	31,774	36,941
Males		
Under 5	42,184	29,120
5 years	8,166	6,694
5-17 yrs.	89,747	99,726
18 years	4,554	6,733
18-59 yrs.	166,157	171,779
60-64 yrs.	12,009	14,585
65+ years	35,646	31,795
Total Males/Females		
Under 5	83,102	57,054
5 years	16,233	12,989
5-17 yrs.	177,306	196,071
18 years	9,229	13,473
18-59 yrs.	325,481	344,113
60-64 yrs.	23,458	28,435
65+ years	65,420	68,736

Source: Montana Department of Community Affairs, County Profiles: 1978.

Table 8

*RESERVATION INDIAN POPULATION, 1970

COUNTY	NUMBER	PERCENT TOTAL POP.
Big Horn	3,917	38.9
Blaine	1,562	23.2
Chouteau	153	2.4
Glacier	4,576	42.4
Lake	2,199	15.2
Phillips	258	4.8
Pondera	546	8.3
Roosevelt	3,110	30.0
Rosebud	1,820	30.2
Valley	972	8.5
Yellowstone	1,063	1.2
TOTALS	20,116	*3.9

SOURCE: 1970 U.S. Census

* 7,014 Indians residing in urban areas.

Exhibit 4

INDIAN RESERVATIONS
in
MONTANA

No. 1052 — County Outline Map
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3. Social Insurance and Welfare

The general trend of recipients receiving welfare assistance is declining. This might be attributed to the decrease in rate of unemployment. During the quarter July-September, FY 1979 there were 51,000 Medicaid recipients at a projected cost of $12.5 million. In June, 1978, the Aid to Dependent Children (ADC) program consisted of 6,120 families at the cost of $1,078,885. The number of ADC family recipients is declining at a slow rate from 7,000 in 1974 to the present level. There were 8,591 families who received food stamps in June, 1978 while 12,000 families received food stamps during July, 1975. The general trend of this program is declining at approximately 50 families per month.

4. Occupational Classifications

Classification of industries for analytical use is divided into two sections: goods producing and service producing. Goods producing, as the name implies, deals in producing goods for consumption and includes the major industry divisions of agriculture, mining, manufacturing, and contract construction. Service producing industries include: trade, services, government, transportation and public utilities, and finance, insurance and real estate.

Since Montana is perceived to be a highly rural state, it is erroneously assumed that the state is highly agrarian. Although agriculture remains Montana's largest export industry, employment opportunities exist in this industry through replacement needs rather than by expansion.[14] Farm workers is the only major occupational group expected to decrease by 1985.[15]

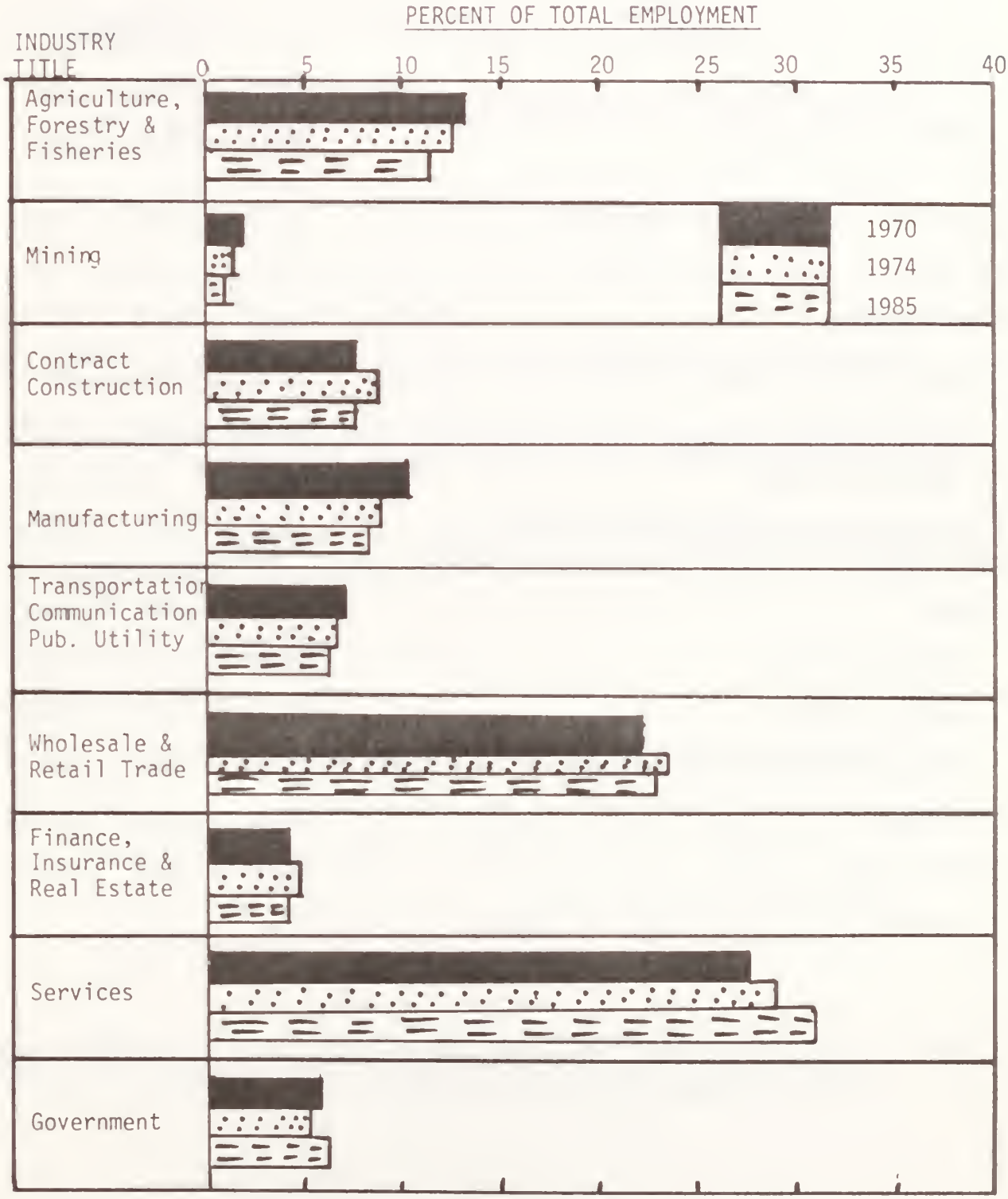
During 1974, white-collar workers --- professional, technical, managers, officials, proprietors, clerical, and salesworkers --- outnumbered blue collar workers --- craftsmen, foremen, operations, and laborers --- by 42,000 jobs. This gap is expected to increase to nearly 60,000 workers by 1985.[16]

As shown in Tables nine and ten , among the most prominent of the state's occupations is services. This amounts to approximately 28 percent of the state's total work force. Wholesale and retail trade workers account for approximately 23 percent of the work force in Montana. Agriculture, forestry, and fisheries account for approximately 13 percent of employment (industry expansion during the period will be attributed to forestry and fisheries rather than to agriculture) while 9 percent is engaged in manufacturing. These four major industries account for approximately 73% of the state's employment rate during 1974.

Table 9

BROAD INDUSTRY GROUPS AS A PERCENT OF TOTAL EMPLOYMENT

IN MONTANA, 1970, 1974, AND PROJECTED 1985



Source: Dept. of Labor and Industries, Research and Analysis Section, Statewide Industry/Occupation Projections-1985-, Oct., 1977.

Table 10

MONTANA EMPLOYMENT BY MAJOR INDUSTRY DIVISION
1970, 1974, AND PROJECTED 1977, 1985

INDUSTRY	EMPLOYMENT			
	1970	1974	1977	1985
TOTAL, ALL INDUSTRIES	254.7	299.5	311.2	342.3
Agriculture, Forestry, Fisheries	34.3	39.6	39.9	40.7
Mining	6.7	7.7	7.7	7.8
Construction	18.1	23.1	23.1	23.2
Manufacturing	24.7	25.6	26.4	28.4
Durable Goods	15.8	16.6	17.4	19.2
Nondurable Goods	8.9	9.0	9.0	9.2
Transportation, Communication & Public Utilities	18.5	21.0	21.2	21.7
Trade	57.1	69.0	71.5	78.2
Wholesale Trade	10.4	12.5	13.0	14.6
Retail Trade	46.7	56.5	58.5	63.6
Finance, Insurance & Real Estate	9.3	11.5	11.9	12.8
Services	71.8	85.6	91.6	107.6
Public Administration	14.2	16.4	17.9	21.9

Source: Dept. of Labor and Industries, Research and Analysis Section, Statewide Industry/Occupation Projections-1985-: Helena, Montana, Oct. 1977.

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SECTION IV

GOALS, OBJECTIVES AND PRIORITIES

OF THE

MONTANA

PRELIMINARY

STATE HEALTH PLAN

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IV. GOALS, OBJECTIVES AND PRIORITIES

A. Definitions

Goals: (Explicit descriptions of) timeless aspirations of desired situation or status of systems' performance.

a. not constrained by time
b. technically achievable
c. philosophically and culturally acceptable
d. an end result, not a method
e. not suggestive of actions, approaches or methods
f. related to desires of major, broad concern to society

Objectives: (Measurable statements of) desired progress toward a goal in a specific time frame.

a. constrained by time; have a specific time frame
b. managerially achievable
c. philosophically and culturally acceptable
d. related either to program outcomes, to implementing systems, or to operations
e. expected to contribute to goal achievement.

Priorities: Measures or characterizations of relative importance of terms or objectives in a set. (Concept assumes that not all things have equal weight.)

For health planning purposes, there are three kinds of goals, objectives and priorities: those that address the health status of a population, those that address the health care system, and those that address the performance of a particular agency, program or institution. Health status and health systems goals are formulated at the national, state and local levels.

B. Introduction

The Montana Statewide Health Coordinating Council (SHCC) and the Montana State Health Planning and Development Agency (SHPDA) must consider several sets of goals, objectives and priorities in developing their own work schedules. They must assist health and health-related programs in state government and in the private sector with planning and goal-setting. They must consider the goals of the Governor, the Montana Health Systems Agency, and the national government. And from all these considerations, they must formulate statewide health goals as well as their own agency goals.

For this preliminary Montana State Health Plan for 1979, the SHCC and SHPDA have chosen to accept the statewide health goals of the Montana Health Systems Agency. This is logical because the geographical planning area of MHSA, the SHCC and the SHPDA is the State of Montana. In future years, the goal-setting process of all three groups will be a joint venture.

However, the SHCC has established its own priority areas for emphasis in this Plan. Also, the SHPDA has set performance goals for itself. These priorities and goals, as well as priorities of the national government and other state entities are addressed below.

C. SHCC Priorities

Through a nominal group process conducted by the SHPDA, the SHCC named the following as priority areas of concern.

1. Public health education in the areas of prevention and health system utilization.
2. Health manpower, facility distribution and alternative health care programs (rural health care delivery).
3. Comprehensive standard coverage under major third-party payors (federal government, the Blues).
4. Environmental health problems.

In addition, the SHCC stated that an absolute and continuing need for Montana health planning is data related to health care costs.

D. SHPDA Goals

1. Stimulate coordination and cooperation among and between all health related organizations and agencies, both public and private, in the delivery of health care services.
2. Provide technical assistance to those agencies and institutions involved in health care services.
3. To enforce statutes, standards and codes relating to establishment and operation of medical facilities, agencies and organizations.
4. Coordinate health planning activities in State Government.
5. To provide Problem-Oriented, Population-Based Analysis, thus providing alternatives to decision and policy makers.
6. To gather and disseminate in understandable form, available data for health planning.
7. To provide public information and education related to the health of Montanans.

E. Governor's Policy Initiatives

Governor Thomas L. Judge, in his policy initiatives, states that the "primary emphasis of the public health program in Montana should be placed on preventive and educational services...the quality of the environment, the calibre of our health care systems, and the nature of the risks we take that are associated with our life styles can be greatly influenced by public and private actions."

F. HSA - Developed Statewide Goals and Priorities

The health goals established by the Montana Health Systems Agency, Inc. in its Health Systems Plan are that:

1. Life expectancy in Montana should be consistent with regional life expectancy rates.
2. All children should be immunized for childhood disease before they reach school age.
3. Persons with chronic disabilities should be able to function to their fullest capacity.
4. The number of deaths in Montana from heart disease should be reduced to at least the average rate for other mountain states.
5. The number of deaths from cancer in Montana should be reduced to at least the average for other mountain states.

The Health Systems Plan also outlines goals and objectives for specific sections of the health care system, such as tertiary services, secondary services and primary services. These goals will be included in the Appendix of the preliminary State Health Plan, Phase II. To date, they are not complete.

The eight health systems priorities of the Montana Health Systems Agency are:

1. Health services should be cost effective.
2. Consumers must share the responsibility for their own health and the costs of health services.
3. Health education programs should be emphasized.
4. More attention should be paid to the social components of health care which should include, but not necessarily be limited to, the special circumstances of the patient, his family, and the resources and constraints of the community.
5. Health services should be coordinated at the local level to the maximum extent possible.
6. Primary care physicians should be recruited to shortage areas.
7. Alternatives to inpatient care should be encouraged.
8. Unnecessary duplication within the health field should be minimized.

G. National Priorities

The ultimate goal of the Montana Statewide Health Coordinating Council, the Montana State Health Planning and Development Agency and the Montana Health Systems Agency, as stated in the National Health Planning and Resource Development Act of 1974 is the "achievement of equal access to quality health care at a reasonable cost."

The ten national priorities under the Act are:

1. The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.
2. The development of multi-institutional systems for coordination of consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care and radiation therapy services).
3. The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.
4. The training and increased utilization of physician assistants, especially nurse clinicians.
5. The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.
6. The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of PSRO's under Part B of Title XI of the Social Security Act.
7. The development of health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.
8. The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.
9. The adoption of uniform cost accounting simplifies reimbursement and utilization reporting systems and improved management procedures for health service institutions.
10. The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

H. State Health Program Goals and Objectives

The goals and objectives of the State health and health-related programs are delineated in Section V of this Plan, the State Program Inventory.

I. Conclusion

The SHCC and the SHPDA are responsible for coordinating health care programs within the state toward the achievement of statewide health goals. Implicit in this is the coordination of the goals themselves. The determination of statewide goals must be a process involving a broad spectrum of health interests. Such a process is outlined in the Introduction to this Plan.

SECTION V

PROGRAMS OF STATE GOVERNMENT

OF THE

MONTANA

PRELIMINARY

STATE HEALTH PLAN

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PROGRAMS OF STATE GOVERNMENT

Introduction

Health and health-related programs of State government will be examined in this section as prescribed by P.L. 93-641. Because of the large investment by State and Federal governments in health care, it is essential that the Preliminary State Health Plan incorporate an examination of State and Federally-sponsored health programs operating in State government agencies. This phase of the Preliminary State Health Plan will address the statutory authority, program mission, description of programs, goals and objectives, evaluation measurements (when available), and expenditures and staffing patterns.

The purposes of the inventory are to: 1) describe program functions and structure; 2) delineate State and Federal funding patterns; 3) portray the goals and objectives of health services and programs by target population; 4) serve as a data base for future program policy and program cost analyses; 5) serve as a data base for future establishment of health priorities and policies; and 6) serve as a data base for future resource allocation decisions.

Much of the information for the inventory was extracted from each agency's Executive Planning Process (EPP) report. These reports, used for the first time this year, were requested by the Governor to aid the Executive Branch in the determination of goals and priorities for the next biennium. Previously, the Executive Branch was using a bulky six-year plan. A brief statement of program mission and current goals and objectives are contained in the EPP's.

It should be noted that goals and objectives did not result in uniform statements of desired results in the inventory. In fact, many of the goals and objectives are actually program functions. However, the State Health Planning and Development Agency and Statewide Health Coordinating Council hope that by publishing this year's EPP reports, more uniform and result-oriented goals and objectives will be developed in future planning efforts.

The second phase of the Preliminary State Health Plan will include policy analysis, also prescribed in P.L. 93-641, which should result in a measurement of the adequacy of programs in the State and a determination of their effectiveness and efficiency in promoting access to quality health care at a reasonable cost.

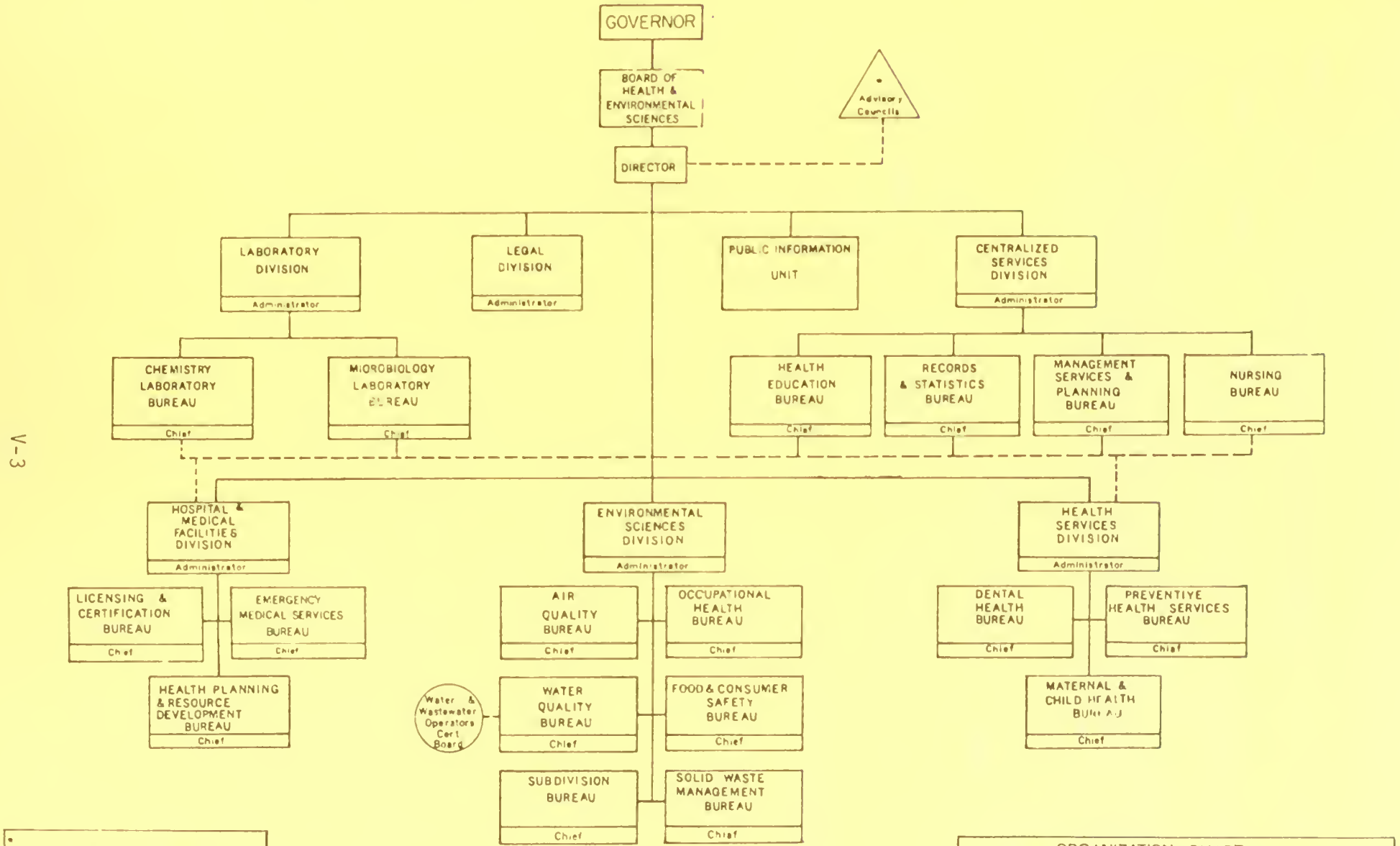
During the development of the government agency's health programs, active participation of government agencies and organizations whose planning and program activities impact on the health status and health systems within the State was solicited. This will foster cooperation among health-related agencies. Coordinative activities should be aimed at eliminating duplicate services and developing goals and long-range actions consistent with the health priorities of the State.

PROPOSED BUDGET SUMMARY FOR HEALTH RELATED SERVICES
Montana State Government
(by Department and Division)
1979
(in millions)

Department/Division	Funding				
	State	Federal	Fees/ Local/ 3rd Party	Sub-Total	Total
Dept. Health & Env. Sci.					
Central Services Div.	$ 416,113	$ 308,377	$	$ 724,490	$
Environmental Sciences Div.	695,208	2,379,810	374,700	3,449,718	
Health Services Div.	815,206	9,267,171	22,000	10,104,377	
Hospital & Medical Facilities	344,317	1,549,938		1,894,255	
Laboratory Division*					
Legal Division	27,109			27,109	
Board of Health	5,000	3,000		8,000	16,207,949
Dept. of Institutions					
Alcohol & Drug Abuse Div.	413,367	688,726		1,102,093	
Mental Health & Res. Serv.	27,868,212	2,987,857		30,856,069	31,958,162
Dept. Labor & Industry					
Safety & Health	631,372	24,574		655,946	655,946
Office Public Instruction					
Basic Instructional Serv.	7,000			7,000	7,000
Dept. of Social & Rehab. Serv.					
Community Services Div.	1,505,225	9,986,335	1,256,506	12,748,066	
Developmental Disabilities Div.	4,903,200	3,567,262		8,470,462	21,218,528
	$37,631,329	$30,763,050	$ 1,653,206	$70,047,585	$70,047,585

* Data currently unknown

DEPARTMENT OF HEALTH
AND
ENVIRONMENTAL SCIENCES


GOVERNOR
BOARD OF HEALTH & ENVIRONMENTAL SCIENCES
Advisory Councils*
DIRECTOR
LABORATORY DIVISION
Administrator
LEGAL DIVISION
Administrator
PUBLIC INFORMATION UNIT
CENTRALIZED SERVICES DIVISION
Administrator
CHEMISTRY LABORATORY BUREAU
Chief
MICROBIOLOGY LABORATORY BUREAU
Chief
HEALTH EDUCATION BUREAU
Chief
RECORDS & STATISTICS BUREAU
Chief
MANAGEMENT SERVICES & PLANNING BUREAU
Chief
NURSING BUREAU
Chief
HOSPITAL & MEDICAL FACILITIES DIVISION
Administrator
ENVIRONMENTAL SCIENCES DIVISION
Administrator
HEALTH SERVICES DIVISION
Administrator
LICENSING & CERTIFICATION BUREAU
Chief
EMERGENCY MEDICAL SERVICES BUREAU
Chief
AIR QUALITY BUREAU
Chief
OCCUPATIONAL HEALTH BUREAU
Chief
DENTAL HEALTH BUREAU
Chief
PREVENTIVE HEALTH SERVICES BUREAU
Chief
HEALTH PLANNING & RESOURCE DEVELOPMENT BUREAU
Chief
Water & Wastewater Operators Cert Board
WATER QUALITY BUREAU
Chief
FOOD & CONSUMER SAFETY BUREAU
Chief
MATERNAL & CHILD HEALTH BUREAU
Chief
SUBDIVISION BUREAU
Chief
SOLID WASTE MANAGEMENT BUREAU
Chief
* Air Pollution Control Advisory Council
Water Pollution Control Advisory Council
Emergency Medical Services Advisory Council
ORGANIZATION CHART
DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
Dec. 1, 1976
Submitted by: _____ Director
Approved by: _____ Governor

CENTRAL SERVICES DIVISION

Statutory Authority: Section 82A, RCM 1947

Description: The Division is a coordinative and administrative unit for the other Bureaus in the Department. The Division comprises two Bureaus: the Management Services Bureau and the Records and Statistics Bureau, and two units: the Planning and Evaluation Unit and the Film Library Unit.

Proposed Budget, FY 1979: $151,000

State Funds	Federal Funds
$67,000	$84,000

Staffing: 2 FTE's

Health Education Bureau

Statutory Authority: Section 69-4110, RCM 1947

Description: The Bureau is supposed to provide technical assistance in health education to other Bureaus within the Department and to other health-related agencies and groups within and outside of State government. However, the Bureau has no staffing or budget. It exists on paper only.

Proposed Budget, FY 1979: -0-

State Funds	Federal Funds
-0-	-0-

Staffing: -0-

Planning and Evaluation Unit

Statutory Authority: Section 82A, RCM 1947

Description: The Planning and Evaluation Unit, created in 1978, provides a variety of coordinative services for the Department as a whole. It serves as a focal point for health education activities, provides staff as a hearings officer and hearings examiner, provides a film library, assists other parts of the Central Services Division with planning and evaluation, acts as the Department A-95 Coordinator, and staff represents the Department as necessary on committees and task forces.

Proposed Budget, FY 1979: $36,000

State Funds	Federal Funds
$25,300	$10,700

Film Library Budget, FY 1979: $10,675

State Funds	Federal Funds
$10,675	-0-

Staffing: 1.5 FTE's (Planning and Evaluation)

1.5 FTE's (Film Library)

Management Services Bureau

Statutory Authority: Section 82A, RCM 1947

Description: The Management Services Bureau provides, for the Department, the services listed below:

budgeting
accounting
planning
purchasing and supply
property control
shipping and receiving
printing
personnel services
mail and communication
space and building service
local health services

Proposed Budget, FY 1979:

State Funds	Federal Funds
$83,138	$147,677

Staffing: 11.65 FTE's

MANAGEMENT SERVICES PROGRAMS

Statutory Authority: Title 69, Sections 82-A-1, Chapters 41 and 44
94-5-619, R.C.M., 1947

Description: Management Services programs within the Department of Health and Environmental Sciences include the Director's office, the Information Unit, the Legal Division and the Central Services Division, which includes the Health Education Bureau, the Planning and Evaluation Unit, the Management Services Bureau, and the Records and Statistics Bureau.

Program Mission: To furnish medical supervision and administrative support to the operating public health programs and to conduct personnel administration and fiscal management by acquiring the personnel, materials, space, and services required in the operation of the departmental programs.

Goals and Objectives: The goals and objectives of the above management services programs were included in one Executive Planning Process report. They are:

a. To provide highest quality legal services and medical, technical and administrative supervision of all agency operations.
b. To develop and implement planning and evaluation systems to utilize outcome measures indicative of optimal cost-benefit and cost-effectiveness strategies.
c. To provide personnel management and staff development services through utilization of merit system and related personnel systems.
d. To provide contract and grants management to encourage maximum utilization of local health services delivery by most applicable local or regional health services delivery agency.
e. To maintain vital records for the people of Montana and provide statistical services for use in development, operation, and evaluation of health services.
f. To continue cooperation with the National Center for Health Statistics in the Cooperative Health Statistics System to insure comparability of Montana data with that of other states in the System and to develop and maintain health manpower and facility files for the use of health program planners at all governmental levels as well as for the general public.
g. To provide consultation and assistance to departmental and local health education agencies in public health education strategies, and to assist those efforts through the operation of film library and other support activities.
h. To inform the public regarding health and environmental programs and actions as mandated by the "Right to Know" provisions of the Montana Constitution.

Director's Office

Statutory Authority: Sections 82A-106 and 601, R.C.M., 1947.

Description: The Director of the Department of Health and Environmental Sciences is appointed by the Governor and serves at his pleasure. The Director is responsible for overall administration and medical supervision of the Department, serves as Secretary of the Board of Health, and is a member of the Governor's Human Services cabinet.

Proposed Budget, FY 1979:

State	Federal
$50,000	$30,000

Staffing 3 FTEs

Information Unit

Statutory Authority: Created by the Department Director, 1974

Description: The Information Unit is responsible for providing health information to the public in a coordinated and understandable manner. This responsibility involves working with Bureaus of the Department and with local health departments in preparing news releases about their activities, in communicating with and through the mass media, in preparing informational workshops and seminars, and in conducting specific health campaigns. In some cases, the Information Unit actually prepares materials for Bureaus and local health departments, but it also assists these entities in preparing their own. The Information Unit also is responsible for publishing a quarterly newsletter, Treasure State Health, about Department activities.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$20,000	$18,000

Staffing: 2.5 FTE's

Records and Statistics Bureau

Statutory Authority: Title 69, Ch. 44, RCM 1947

Description: The Bureau is responsible for the collection, compilation and maintenance of vital statistics on births, deaths, fetal deaths, abortions, mariages, and marriage dissolutions. It issues birth and death certificate duplicates, processes adoption certificates, provides data assistance to other Bureaus, publishes an annual vital statistics reference guide, and reports vital statistics to the National Center for Health Statistics System.

Proposed Budget, FY 1979: $178,000

State Funds	Federal Funds
$160,000	$18,000

Staffing: 13.5 FTE's

ENVIRONMENTAL SCIENCES DIVISION

Statutory Authority: All or portions of Title 69, 16, 27, 34, 57, 75, R.C.M., 1947

Description: The Environmental Sciences Division provides administration for six bureaus: Air Quality, Food and Consumer Safety, Occupational Health, Solid Waste Management, Subdivision, and Water Quality.

Program Mission: The program mission of the Division is "to protect our most important resource - human health - from the increasingly apparent problem of hazardous substances in the environment, and to the greatest degree practicable, prevent injury to plant and animal life and property, foster the comfort and convenience of the people, promote the economic and social development of the state, and facilitate the enjoyment of the natural attractions of the state."

Goals and Objectives: Current goals and objectives of the Division, as listed in the Executive Planning Process:

a. To secure and maintain for every citizen in the state a safe and adequate water supply.
b. To secure and maintain a high level of food protection in a food processing and retail establishment.
c. To secure and maintain safe air for breathing.
d. To secure and maintain safe and adequate sewage disposal, hazardous wastes, and garbage and trash disposal throughout the state.
e. To secure and maintain every work place free of occupational disease.
f. To prevent and control vector-borne disease.
g. To prevent and control deterioration of surface and ground waters throughout the state.
h. To prevent and control unnecessary degradation of air quality throughout the state.
i. To provide a system of surveillance and monitoring of all areas of the environment where any potential public health problem exists.
j. To provide technical assistance, consultation and guidance to individuals, local agencies, and other state departments.
k. To provide educational materials, personal visits, and communications to all citizens of the state requesting assistance in environmental matters.
l. To perform studies and examinations in any area relative to any component of the environment which may be suspected of causing or contributing to ill health or deterioration of the general environment.

m. To provide for surveillance of hotels, motels, jails, state institutions and swimming pools.
n. To reduce accidents and death rates caused by products used in and around the home and for recreational purposes (Consumer Product Safety).

Proposed Budget, FY 79:

State: $80,124 Federal: $10,540

Staffing: 4.25 FTE's

Air Quality Bureau

Statutory Authority: Sections 69-3906, 3923, R.C.M., 1947
Federal Clean Air Act

Description: The Air Quality Bureau is responsible for protecting human health and welfare, animal and plant life and property from dangerous and interfering levels of air contaminants. To perform this responsibility the Bureau has four sections: enforcement, engineering, ambient air monitoring, and technical services.

The enforcement division uses the Bureau's regulatory powers to enforce air pollution laws and to issue permits. An engineer is assigned to each of the five Air Quality Control Regions in Montana. These engineers are responsible for construction permits, tax certifications, environmental impact statements, plant inspections, and source testing.

The ambient air monitoring section is responsible for air quality monitoring, equipment maintenance and repair, the development of ambient air quality standards and criteria, responding to hazardous waste in the air, and coordination of chemical laboratory work.

The technical service section provides technical assistance in the area of meteorology, statistics, diffusion monitoring, data processing, modeling, stagnation, coal fields and energy areas, transportation, air quality maintenance plans, and other activities.

In addition, the Air Quality Bureau has branch offices in Kalispell and Billings and conducts numerous special projects, including a two-year, federally-funded Montana Air Pollution Study.

Proposed Budget, FY 79:

State: $131,845 Federal: $1,179,204

Staffing: 22.38 FTE's

Food and Consumer Safety Bureau

Statutory Authority: Sections 16-4205, 16-4209, 27-611, 27-701 through 27-723, 34-301, 69-4110, 69-4118, 69-7101, 69-5603 and R.C.M., 1947 and 16-2.14 (2)-S14120ARM

Description: The Food and Consumer Safety Bureau is responsible for providing training and consultation to local sanitarians and to 29 local Health Departments in the State in six functional programs.

The goals and objectives for each of the six programs, as they were outlined in the Executive Planning Process report, will be reported in each program section.

1. Public Establishments Program (including public food service establishments, bars, general public housing, hotels and motels, trailer courts, campground and migrant worker housing and the related environment.)

Goal: To protect public health through the prevention of unsanitary, unhealthy and environmentally unacceptable and degrading conditions in public establishments.

Objectives:

1. To license all establishments;

2. To implement an adequate survey program for all licensed establishments;

3. To investigate all reports of food-borne illness which may be associated with licensed establishments;

4. To provide consultative, educative, administrative and evaluative services to 29 local public health agencies and the 7,113 operations currently subject to public health protection inspections and evaluations.

2. Jails and Institutions Program (including schools, Job Corps camps, homes for the developmentally disabled, and homes for the emotionally disturbed).

Goal: To ensure the environmental quality of jails and institutions.

Objectives:

1. To provide public health surveillance to the 16 state institutions and approximately 100 local jails throughout the state.

   a. Accomplish one routine inspection for each facility per year.

   b. Accomplish reinspections in ten percent of all facilities per year.

2. To provide food service training to those institutions and larger jails needing or desiring this service.

3. To provide training to local sanitarians in their duties relating to this program and other programs of the Bureau.

3. Food, Drugs and Cosmetics Program

Goal: To protect the consumer from adulterated or misbranded foods, drugs or cosmetics.

Objectives:

1. To inform and educate consumers, retail store operators, and manufacturers in preventing food, drug and cosmetic product adulteration and/or misbranding.

2. To provide thorough investigations of all reports of adulterated and/or misbranded foods, drugs or cosmetics.

3. To prevent damaged, hazardous, and distressed consumer products (i.e., accidents, floods, fire damaged products) from being used for humans and animals.

4. To provide complete, thorough inspections for all food, drug and cosmetic manufacturers and warehouse storage and labeling reviews of proposed labels on products manufactured in the state.

4. Consumer Product Safety Program

Goal: Reducing accidents resulting from the use of consumer products through informational, educational and investigative activities.

Objectives:

1. To acquaint consumers with cause and prevention information in regard to consumer products (through increased usage of media, seminars, etc.)

2. To improve consumer knowledge of what to do - who to contact if a consumer commodity has or is expected to cause or result in injury and respond to consumer complaints regarding such com-complaints or injuries.

3. To affect quality of consumer goods in Montana through improved inspection, injury education, information, and sampling of such goods.

4. To increase involvement of local health jurisdictions in an active consumer safety program on a local level.

5. To improve reporting of product relative accidents due to consumer products.

5. Vector Control and Pesticides Program

Goal: Protecting the public health by control of insect and rodent populations.

Objective:

1. To increase the effectiveness and environmental soundness of local vector control services through provision of local organizational assistance and through consultive, administrative, educational, and technical laboratory, and field services designed to extend local technical, financial and biological control resources.

6. Swimming Pools Program

Goal: To ensure the environmental quality and the safety of swimming pools.

Objectives:

1. To review and approve plans.

2. To provide surveillance through local health departments.

3. To provide training and technical assistance for pool managers.

Output and Effectiveness Measures Used by the Bureau Include:

1. Periodic surveys of food service establishment programs by the state office in every health jurisdiction to ensure standard procedures are followed by each sanitarian.

2. Evaluation of Sanitarian Education Conference.

3. Acceptance of services by local health departments.

Proposed Budget, FY 1979:

State	Federal
$117,363	$92,039

Staffing: 14 FTEs

Occupational Health Bureau

Statutory Authority: Section 16-2.14(6) - S14270, S14280, S14290, S14300, S14310

Description: The Occuaptional Health Bureau is responsible for protecting workers from exposure to irritating or toxic materials, and to protect workers and the public from exposure to unnecessary radiation and unhealthy levels of noise. The Bureau accomplishes these responsibilities through the following activities:

a. Inspecting governmental (state, county, city) work places for worker exposure to irritating or toxic materials including air contaminants, noise, contact exposures or ultraviolet light exposures;
b. Inspecting other work places for worker exposure to irritating or toxic materials on request or as an investigation of a complaint;
c. Providing technical assistance to communities in writing noise control ordinances, training noise control personnel, selection of sound level instruments, etc., as part of an overall noise control program;
d. Responding to all emergencies in the state resulting from loss of control of radiation materials or other hazardous materials;
e. Inspecting and monitoring all electronically-produced radiation such as that from medical and dental x-ray, fluoroscopes, reactors, isotopes, microwaves, lasers, etc.;
f. Inspecting well logging, uranium mines, design radiation;
g. Controlling radiation from by-product materials;
h. Providing technical assistance in reducing exposure to radiation and irritating or toxic materials.

Proposed Budget, FY 1979:

State: $76,733 Federal: $5,657

Staffing: 5 FTEs

Solid Waste Management Bureau

Statutory Authority: Title 69, Chapters 40, 60, and 68, R.C.M., 1947. Montana Administrative Codes: 16-2.14(2)-S14261 16-2.14(2)-S14100

Description: The Solid Waste Management Bureau protects the public health by ensuring that solid wastes are properly disposed. As primarily a regulatory agency, the Bureau works closely with county commissioners, local health officers, sanitarians, and county attorneys in the enforcement of laws pertaining to solid waste disposal. The Bureau has six functional areas: sanitary landfills and other disposal methods, refuse disposal districts, resource recovery, junk vehicles, hazardous wastes, and training and information.

In regards to sanitary landfills, the Bureau approves landfill plans and sites, and periodically inspects the operation of these disposal areas. The Bureau also will investigate any complaints. State law requires that anyone operating a refuse disposal area must obtain a license from the local, county, or district board of health. The Bureau also helps with the establishment of refuse disposal districts.

Under the Junk Vehicle Act of 1973, each motor vehicle wrecking facility in the state must be licensed by the Department of Health and Environmental Sciences. Inspections of wrecking facilities are conducted by the Solid Waste Management Bureau and local sanitarians. Each county is required to provide a free junk vehicle graveyard to which anyone can deliver a junk vehicle. The Bureau is then responsible for the final disposition of accumulated junk vehicles through contracts with private firms. The junk vehicle program is funded by a special fee on motor vehicle titles and from the sale or recycling of junk vehicles.

The resourse recovery section of the Bureau is responsible for recycling, source reduction and energy production.

In hazardous wastes, the Bureau conducts emergency response to hazardous materials episodes, operates and controls hazardous waste storage and disposal, investigates waste pesticide land disposal techniques, and performs statewide surveys and surveillance of hazardous waste disposal by hospitals and industries.

In the area of training and public information, the Bureau puts out training films, pamphlets and news releases and provide safety courses, as well as other activities.

Proposed Budget, FY 79:

Fees: $374,700 Federal: $210,290

Staffing: 11 FTE's

Subdivision Bureau

Statutory Authority: Sections 69-5001 through 69-5009, R.C.M., 1947.

Description: The Subdivision Bureau regulates the sales of subdivided land, which is defined as any division of land that creates one or more parcels of less than 20 acres. In regulating such sales, the Bureau works with County Clerk and Recorders and Local Planning Boards.

The three functional sections of the Bureau are sanitary engineering, community assessment and development, and systems development and evaluation.

The Bureau has a branch office located in Kalispell.

Basically, the Bureau and local planning boards, review plans for water supply, sewage disposal, solid waste disposal, storm drainage, soil mechanics, geology, hydrology, dust control, and flood plains.

Proposed Budget, FY 79:

State: $67,007 Federal: $135,162

Staffing: 8.5 FTE's

Water Quality Bureau

Statutory Authority: Sections 69-4801 through 69-4827, R.C.M., 1947

Description: The Water Quality Bureau is responsible for the prevention and correction of water pollution.

To carry out this responsibility, the Bureau has nine sections:

1. Municipal Water Supply, including the review of municipal water supply plant, annual inspection of water supply systems serving the public, and consultation with local operators on water supply problems.

2. Sewage Disposal, including the review of sewage disposal plans, inspections of sewage disposal sites, and provisions of assistance and training to operators.

3. Municipal Construction Grants for Sewage Disposal. In a liaison capacity with the Federal Environmental Protection Agency, the Bureau establishes priorities and reviews applications, facility plans, construction plans and specifications for municipal construction grants. It also assists the grant applicants.

4. Industrial and Municipal Permits, including the issuing of waste discharge permits, monitoring the waste discharge of municipalities and industrial plants to ensure compliance, and reviewing plans for waste discharge compliance with Federal laws.

5. Stream Monitoring, including stream sampling and water pollution studies.

6. Water Quality Management Monitoring, including inventorying and sampling testing streams to determine specific water pollution problems and recommending areas for water quality improvement.

7. Water and Wastewater Operator Certification, including the training, licensing, and examining of local water operators.

8. Agricultural Wastewaters, including issuing permits to feedlot and irrigation operators and erosion control.

9. Enforcement, including assuring permit compliance, investigating complaints and water quality standard violations.

In addition, the Bureau has branch offices in Kalispell and Billings and conducts a number of special projects.

Proposed Budget, FY 1979:

State: $222,136 Federal: $746,918

Staffing: 35.75 FTEs

HEALTH SERVICES DIVISION

Statutory Authority: 82A-601

Description: The Health Services Division is charged with the overall administration and coordination of four bureaus: Dental Health, Maternal and Child Health Services, Nursing, and Preventive Health Services.

Program Mission: The Program Mission of the Health Services Division, as stated in the Executive Planning Process Report, is "To protect and improve the health of the people of Montana through positively influencing the provision of community and individual health services not elsewhere available. These activities include the provision of preventive, therapeutic, consultative and supportive health services to individuals and communities."

Goals and Objectives: The Goals and Objectives provided by the Division in its Executive Planning Process Report are as follows:

a. To provide maternity and infant health services to 1,200 high-risk pregnant women and 1,200 infants per year.
b. To provide case management, clinic evaluations, and financial assistance to 1,100 children per year with physical handicapping conditions.
c. To provide investigation of suspected non-infectious disease hazards, including environmental carcinogens, in order to develop effective preventive methods.
d. To provide family planning services to 22,800 individuals per year.
e. To provide primary health care or well-child services to 10,000 children per year.
f. To provide nutrition counseling and food to 2,000 pregnant and lactating women, 10,000 preschool children, and 300 school-age children per year.
g. To provide dental health education and preventive services to 55,000 children and dental care to 2,000 children per year.
h. To assist communities to provide screening, patient education, continuity and coordination of care, and community services for individuals with actual or suspected Diabetes Mellitus, Hypertension, and certain cancers.
i. To provide continuing education and specialty consultation to local health personnel.
j. To manage the screening and follow-up for inborn errors of metabolism for all children born in Montana hospitals.
k. To provide health screening of 2,500 Medicaid children per year.

The following narrative will present a brief overview of each bureau's program(s), budget, staffing pattern, and method of measuring program output and effectiveness.

Health Services Administration of Division

Statutory Authority: Title 69
R.C.M. 1947

Description: This management group works with Health Services bureau chiefs, program managers, and local health officers to establish planning criteria and evaluation techniques and standards. They also provide assistance for ensuring attainment of goals and objectives of the organization. Administration plays an increasing role as community level emphasis includes the provision of preventive, therapeutic, consultative, and supportive health services. Through coordinating and integrating resources, the provision of community health services is more available to protect and improve the health of Montana citizens.

Evaluation:
--Number of programs in performance standards.
--Number of programs clearly demonstrating declared effectiveness.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$177,157	$139,977

Staffing: 9.0 FTE's

Maternal and Child Health Services Bureau

1. Handicapped Children Service

Statutory Authority: Title 69, Chapters 41, 67 and 69
R.C.M. 1947

Description: The Handicapped Children Service Program is primarily responsible for the provision of a broad spectrum of medical services to children with handicaps of a chronic nature and newborn infants in need of special intensive medical care. Whenever possible, an interdisciplinary team approach is used for diagnosis and evaluation. A comprehensive evaluation includes the following:

--health assessment
--medical evaluation
--social assessment
--psychological assessment
--vocational assessment

These services are generally purchased from and through private medical care specialists.

Secondary services include prevention activities, health and nutritional counseling, and follow-up in addition to assisting families in eliminating factors which interfere with receiving medical care. The indicated services should play an important role in reducing the incidence of debilitating health problems to an increasing number of children.

Evaluation:
--645 children evaluated
--628 children receiving program assistance for medical care
--Transportation of 55 newborns

Proposed Budget, FY 1979:

State Funds	Federal Funds	Fees
$239,038	$814,949	$17,000

Staffing: 16.25 FTE's

2. Maternal and Child Health Projects

Statutory Authority: Title 69, Chapter 41 and 67
R.C.M. 1947

Description: The Maternal and Child Health Program provides health service to high risk pregnant women, infants, and children through health screening, consultation and education, referral, treatment, and follow-up services. In addition, the program provides screening and follow-up for inborn errors of metabolism for all children born in Montana hospitals. These services are provided through contracts with local health providers, health departments, and by referral to appropriate specialists.

Evaluation:

- --Number of children screened for unsatisfactory health conditions including inborn errors of metabolism, handicapping conditions, and general health.
- --Number of children referred for further diagnosis and medical treatment.
- --Number of high risk mothers and infants under managed health care during prenatal period.
- --Number of pre-school children enrolled in well-child programs.
- --Percent of all screened children with identified health problems who are confirmed to be under appropriate medical management.
- --Percent of target area high risk population (where high risk birth occurs) who were under prenatal managed health care.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$44,870	$759,774

Staffing: 6.5 FTE's

3. Family Planning Program

Statutory Authority: Title 69, Chapters 41, 45, 61, 67 and 69 R.C.M. 1947

Description: The Family Planning Program is responsible for the provision of family planning information, education, and health services on request. Through supplying these services, women are assisted in limiting and spacing children, reducing the incidence of premature births, and birth defects, and increasing preventive health measures. This effort is in accord with the national endeavor to reduce unwanted, premature, and defective births with special emphasis on the increasing incidence of teenage pregnancies. Thus, this program plays a significant role in the preventive health planning effort.

Evaluation:

- --Number of clients served by income level.
- --Number of clients receiving diagnostic tests for cancer and venereal disease.
- --Number of clients referred for other professional care.
- --Percent of all female clients not desiring children who do not become pregnant while enrolled in the program.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$43,830	$1,125,154

Staffing: 12.66 FTE's

4. Nutrition Program

Statutory Authority: Title 69, Chapters 41, 67 and 69
R.C.M. 1947

Description: The Nutrition Program provides health and nutritional services to families below the 80% median income guidelines. This program is coordinated with programs in the Department of Health and the Department of Social and Rehabilitation Services and involves Detection, Family Planning, Handicapped Children, Licensed Day Care Centers, Group Homes, and all Maternal and Child Health programs. Services include counseling, nutritional food packages, and education in nutrition and health care. Training and consultation workshops are furnished to public health professionals. The population served is pregnant women, women in childbearing years, and infants and children of high risk groups. Much effort is aimed toward reducing the number of children who experience health problems and/or developmental disabilities due to poor nutrition after birth or poor nutrition of the mother during the gestation period. This is in harmony with the national undertaking. The Nutrition Program improves the health status of Montana's specified women and children by reducing the prevalence of iron deficiency anemia, obesity, underweight, and other nutrition related health factors.

Evaluation:

- --Number of women, infants, and children receiving nutritional services.
- --Number of women, infants, and children receiving supplemental foods.
- --Number of women, infants, and children receiving meals in a nutritional management setting.
- --Percent spread (indicating improvement) between infants and children excessively over/underweight or anemic on initial contact and those who exceed standards on subsequent contacts.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$8,408	$6,018,110

Staffing: 17.99 FTE's

Dental Health Bureau

Statutory Authority: Title 69, Chapters 41, 67 and 69
R.C.M. 1947

Description: The Dental Health Bureau is responsible for providing dental health services to Montana's children by coordinating efforts in several elementary schools. Through a comprehensive, preventive dental care program, low income children are receiving professional care. There has been a significant impact on the health status of children served in the flouride (preventive) program.

Evaluation:
- --Number of children receiving dental care assistance.
- --Number of children receiving dental prevention training.
- --Percent of children served by severity of teeth and gum condition.

Proposed Budget, FY 1979:

State Funds	Federal Funds	Fees
$35,224	$91,835	$2,500

Staffing: 3.0 FTE's

Nursing Services Bureau

Statutory Authority: Title 69, Chapters 41, 67 and 69
R.C.M. 1947

Description: The Nursing Services Bureau provides consultation, continuing education opportunities and supervision to community and school nursing services through the Bureau and traveling nurse consultants. This coordinating body for public health and school nurses is increasing its role to include preventive health and home health care.

Evaluation:
- --Number of nurses served.
- --Number of hours of consultation per nurse served.
- --Number of home health agencies added.
- --Percent of state population covered by home health services.

Proposed Budget, FY 1979:

State Funds	Federal Funds	Fees
$88,578	$52,967	$2,500

Staffing: 6.5 FTE's

Preventive Health Services Bureau

Statutory Authority: 82A-601

Description: The Preventive Health Services Bureau has the responsibility for all immunization activities, venereal disease control, tuberculosis control, epidemiological surveillance and/or follow-up of all communicable diseases in Montana as well as chronic disease prevention and special investigation of all suspect disease hazards. There are three principal areas of involvement by the Bureau: Communicable Disease Control, Chronic Disease Control and Special investigations. The Special Investigation section addresses problems related to the occurrence of specific, generally non-communicable diseases or possible health threats.

The two principal areas of involvement will be subsequently reviewed and will include the Executive Planning Process report's Mission Statements and Goals and Objectives in addition to program descriptions, budget and staffing patterns.

Program Mission: The Program Mission of the Communicable Disease Control Section, as stated in the Executive Planning Process report is, "To protect and improve the health of the people of Montana through prevention and control of communicable (infectious) disease."

Goals and Objectives:

a. To assure adequate treatment and necessary epidemiologic investigation for all cases of infectious ("active") tuberculosis; and identify and preventively treat all persons at high risk of developing tuberculosis.

b. To assure provision of adequate, appropriate, and accessible therapy and preventive (epidemiologic) services to all patients with venereal diseases, principally gonorrhea and infectious syphilis.

c. To prevent any cases or outbreaks of measels, rubella, congenital rubella, polio, tetanus, whooping cough and diphtheria through appropriate immunization of all school children and 90% of preschool age children, and through provision of necessary vaccines and epidemiological services.

d. To maintain surveillance on reportable communicable diseases, provide epidemiologic investigation and analysis as indicated, and to transmit this information in a meaningful form at regular intervals to all persons in the state concerned with the detection, investigation, treatment or prevention of these diseases, and to institute or encourage central measures as necessary.

e. To provide quality diagnostic microbiology laboratory services necessary for the detection, therapy, investigation and prevention of communicable diseases.

f. To provide investigation of suspected non-infectious disease hazards, including environmental carcinogens, in order to develop effective preventive methods.

g. To assist communities to provide screening, patient education, continuity and coordination of care, and community services for individuals with actual or suspected Diabetes Mellitus, Hypertension, and certain cancers.

A. Communicable Disease Control

Statutory Authority: Title 69, Chapters 41, 43, 45, 46, R.C.M., 1947

1. Immunization Program

Description: The goal of this program is to prevent the occurrence of poliomyelitis, rubella, congenital rubella, rubeola, diphtheria, tetanus, and whooping cough through immunization of pre-school and elementary school children. Vaccine and assistance is provided to local health departments, Indian Health Service, Day Care Center, Sunday Schools, Title I Schools, and Well Child Clinics for use in regularly scheduled immunization programs. In addition to the aforementioned direct service, the bureau also receives reports on the occurrence of any of the six diseases (listed above) from private physicians, local health officers, public health nurses, schools, laboratories, and other sources. These data are used to identify communities where a concentrated immunization program is needed, or where prompt investigation is necessary for effective disease control (outbreak control).

Proposed Budget, FY 1979:

State Funds	Federal Funds
$750	$107,813

Staffing: 4.6 FTE's

2. Venereal Disease Control Program

Description: The goal of this program is to reduce and eventually eradicate venereal disease in Montana. This is primarily an educational program directed toward groups and communities. Much of the educational effort is directed at informing younger people about the symptoms of venereal disease and treatment services in their area. In addition to the above, the bureau provides educational pamphlets, lectures, movies, and technical and medical advice regarding venereal disease and maintains a toll-free statewide "VD Hotline" as a service to anyone seeking information about venereal disease. Also, surveillance and tracing activities are an important part of controlling the spread of venereal disease through the cooperation of the entire medical community, as well as encouragement and support of acceptable venereal disease clinics (and screening activities).

Proposed Budget, FY 1979:

State Funds	Federal Funds
-0-	$71,867

Staffing: 2.60 FTE's

3. Tuberculosis Control Program

Description: The goal of this program is to control and prevent active tuberculosis (TB) and reduce mortality from TB. The primary function of the bureau in this program is to coordinate activities of local health departments and Indian Health departments and Indian Health Services in diagnosing active TB cases and ensuring that the necessary medical and epidemiologic services are available to prevent the spread of TB. All cases of TB must be reported and investigated. The bureau maintains evaluative statistical data on the incidence and control of TB.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$31,313	$26,919

Staffing: 3.40 FTE's

4. General Communicable Disease Control Program

Description: The purpose of this program is to promote the control of focal or epidemic occurrence of diseases that are considered hazardous to the public health. This program serves communities rather than individuals, and is directed toward the prevention of communicable diseases through technical and professional consultation with health departments, doctors, and others, and also through education and information of the general public. Whenever a serious outbreak of a communicable disease occurs, coordinated special investigations are conducted and control measures are implemented. Diagnostic and therapeutic assistance is provided by the Bureau.

Proposed Budget, FY 1979:

	State Funds	Federal Funds
Biological	$ 3,000	$ 1,962
Communicable Disease	$10,465	$12,419

Staffing: 1.40 FTE's

A. Chronic Disease Control and Special Hazards Investigation

Statutory Authority: 69-4110(2), (see also Chapters 41 and 45, R.C.M., 1947)

Program Mission: To protect and improve the health of the people of Montana through prevention and control of chronic disease.

1. Chronic Disease Control Program

Description: The purpose of this program is to reduce the mortality and morbidity caused by chronic disease, particularly hypertension, diabetes mellitus, heart disease, (including rheumatic heart disease) and cancer. This is primarily an educational program directed at communities. The Bureau assists hospitals, local health personnel, and other community groups to develop education programs, screening programs, follow-up, and general planning and strategy.

Proposed Budget, FY 1979:

	State Funds	Federal Funds
Chronic Disease	$28,783	$ 1,000
Diabetes Mellitus	$12,694	$ 1,400
Hypertension	$17,402	$34,225
Rheumatic Fever Prevention	$ -0-	$ 3,500

Staffing: 3.4 FTE's

2. Special Investigations

Description: Special investigations are conducted as necessary and are usually not communicable diseases. They usually involve the Bureau Chief as a consultant to another bureau or agency in designing a study, i.e., possible relationship of environmental pollution to respiratory diseases (e.g., lung cancer).

Proposed Budget, FY 1979:

State Funds	Federal Funds
$2,000	$500

Staffing: -0- FTE's

Administration of Bureau

Description: The responsibility of the Bureau Chief and support staff is to amend existing or initiate new legislation to further the Bureau's objectives. Also, they manage fiscal, personnel, and other management matters and ensure delivery of preventive health services.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$71,694	$2,800

Staffing: 2 FTE's

HOSPITAL AND MEDICAL FACILITIES DIVISION

Statutory Authority: 69-7001, 69-7002, 69-7003, 69-7010, 69-3601, 69-3613, 69-5201 through 5220, 69-4110.1, RCM, 1947.
PL 87-92, PL 93-641.

Description: The Hospital and Medical Facilities Division comprises three Bureaus: the Emergency Medical Services Bureau, the Health Planning and Resource Development Bureau, and the Licensing and Certification Bureau. The Division Administrator coordinates and provides support services to the Bureaus.

Emergency Medical Services Bureau

Statutory Authority: Title 69, Chapters 36, 70 and 84, RCM, 1947

Description: The Emergency Medical Services Bureau is responsible for developing and coordinating all facets of a statewide emergency medical services system.

Program Mission: The establishment and continuation of high quality, comprehensive statewide emergency medical system to reduce mortality and morbidity of Montanans and visitors.

Goals and Objectives: The goals and objectives of the program, according to the Executive Planning Process, are:

a. To enforce the ambulance licensing law, including annual inspections of 106 services and establishment of a comprehensive emergency transportation system (air, ground and water).
b. To implement the new Emergency Medical Technician Certification program, including testing for Montana Board of Medical Examiners.
c. To provide federal grant funding to local governments for equipment purchases and other activities to improve local/regional EMS systems in accordance with guidelines of the federal granting agency--DHEW.
d. To develop EMS systems of care for critically injured patients in total cooperation with organized physician groups and other health care providers in Montana to reduce mortality/morbidity.
e. To establish excellent emergency medical training and continuing education programs for emergency medical technicians, physicians, nurses, public safety personnel and the general public (public information and education).
f. To provide technical assistance to local governments, hospitals, EMS Councils, ambulance services and others.

g. To establish an adequate evaluation and data collection system for determination of need, problem areas, cost allocation, program planning and system effectiveness.

Evaluation: The Bureau is in the process of establishing an evaluation system for emergency medical services that will include measures of:

a. Ambulance response times, nature and scope of patient complaints, and pre-hospital treatment procedures.
b. Nature and scope of critical illnesses and injuries treated in Montana's hospitals, including patient outcome, transfer patterns and length of stay.

The evaluation system, however, depends on obtaining reliable data from ambulance services and hospital medical records departments.

Proposed Budget, FY 1979: $867,274

State Funds	Federal Funds
$155,774	$711,500

Staffing: 12.54 FTE's

Licensing and Certification Bureau

Statutory Authority: Title 69, Chapter 52, RCM, 1947.
Federal Titles XVIII and XIX (Medicare and Medicaid)

Description: The Licensing and Certification Bureau inspects and licenses all hospitals, nursing homes and home health agencies, infirmaries and outpatient clinics within the state, in compliance with state medical facilities licensing codes. It also surveys those institutions or agencies requesting certification under Medicare and Medicaid.

Program Mission: As stated in the Executive Planning Process, the mission of the Bureau is "to license all health facilities and services, as required by State statute, and to survey and certify or recommend certification, at least annually, of all providers of Medicare and Medicaid services."

Goals and Objectives: The Executive Planning Process lists the following goals and objectives for the Licensing and Certification Bureau:

a. To provide for continuing public safety and welfare through the health facilities licensing sub-program.

b. To assure that quality patient care is provided in a safe environment and in compliance with the conditions of participation for Titles XVIII and XIX.

c. To respond to the public by investigating any complaints about health care providers under the Bureau's jurisdiction.

Proposed Budget, FY 1979: $487,986

State Funds	Federal Funds
$50,524	$437,462 (still being negotiated)

Staffing: 21.08 FTE's

Health Planning and Resource Development Bureau

Statutory Authority: 69-4110.1, 69-5212 and 69-5219, RCM 1947
PL 93-641

Description: The Health Planning and Resource Development Bureau (also known as the State Health Planning and Development Agency or SHPDA) is responsible for coordinating all health planning and implementation activities within the State, with special emphasis on State government programs.

Program Mission: Federal legislation (PL 93-641) mandates for a State Health Planning and Development Agency (SHPDA) which shall be an arm of State government designated by the Governor "to conduct health planning activities of the State" and implement planned objectives relating to State government.

Goals and Objectives: The current goals and objectives of the Bureau, as outlined in the Executive Planning Process, are to perform the functions of a State Health Planning and Development Agency (SHPDA) as specified in PL 93-641. Those functions include:

a. Writing a State Health Plan (SHP) and a State Medical Facilities Plan (SMFP) which address cost containment in health care, the need for health services, the proper delivery of health services, the proper distribution of health resources, an analysis of state health policy, and an inventory of medical facilities and services.
b. Implementing those parts of the SHP and SMFP which relate to the government of the State.
c. Administering a State Certificate of Need Law and Section 1122 of the Social Security Act.
d. Collecting and coordinating the data necessary for health planning and health resource development.
e. Administering Title 16 of PL 93-641 (Hill-Burton), relating to medical facilities construction.
f. Administering the construction portion of the State Hospital and Medical Facilities Licensing Act.
g. Coordinating the health planning activities of other state government agencies, private health agencies, and health providers. In particular, coordinating with the Montana Health Systems Agency, also mandated under PL 93-641.

Proposed Budget, FY 1979: $538,995

State Funds	Federal Funds
$138,019	$400,976

Staffing: 15.48 FTE's

LABORATORY DIVISION

Statutory Authority: 69-4110 , RCM 1947
Montana Administrative Codes:

16-2.18(6) - S1820, S1840
16-2.22(1) - S2200
16-2.26(1) - S2600
16-2.26(2) - S2610
16-2.26(2) - S2620

Description: The Laboratory Division is responsible for overall administration and coordination of two Bureaus: the Chemistry Laboratory Bureau and the Microbiology Laboratory Bureau. However, at this time, the Division Administrator position is vacant and the Division has no budget or staffing separate from that of the two bureaus.

Chemistry Laboratory Bureau

Description: The Bureau provides laboratory services and consultation to programs of the Environmental Sciences Division and serves as a State reference laboratory for difficult and unusual procedures.

Goals and Objectives: The goals and objectives as stated in the Executive Planning Process report are:

- Analyze air, water, food, occupational health, and other samples submitted by or through the Environmental Sciences Division.
- Maintain legally defensible chain-of-custody on samples involved in enforcement.
- Analyze private drinking water samples.
- Develop and administer a certification program for laboratories performing chemical analyses of public water supplies.
- Increase reliability of data (quality control) and laboratory efficiency.
- Provide chemical consultation.
- Research and develop new analytical methods.
- Conduct training course in chemical methods for waste water operators and private laboratory analysts.

Proposed Budget, FY 1979:

	State Funds	Federal Funds	Other
	$65,984	$125,311	$20,080

Total Funds: $211,375

Staffing: 10.8 FTE's

Microbiology Laboratory Bureau

Description: The Microbiology Laboratory Bureau has four functions:

1. To provide laboratory testing services in support of communicable disease control and environmental sciences programs.

2. To provide training and consultation for local laboratory personnel in support of the hospital and medical facilities and manpower program.

3. To approve laboratories for performance of microbiology and premarital serology, as required by State law.

4. To certify laboratories engaged in microbiological analysis of drinking water, as required by the Safe Drinking Water Act.

Laboratory services are offered for tests which cannot be performed practically by local laboratories, for specimens referred to the State Laboratory for confirmation or consultation and for communicable disease investigation or surveillance by State or county public health officials. These include clinical, bacteriology, virology, serology, mycobacteriology (TB), mycology, parasitology, and food and water microbiology. Water laboratory certification is carried out by regular on-site inspections and performance review. Approval of laboratories for premarital and prenatal serology is accomplished through a direct proficiency testing program. Training and consultation for local clinical laboratory personnel are provided in the form of bench training at the State Laboratory, workshops in outlying communities and other continuing education activities. Technical assistance is also provided in support of the work of the Bureau of Licensing and Certification.

Goals and Objectives: The Bureau's goals and objectives were included in the Executive Planning Process report for the Health Services Division.

Proposed Budget, FY 1979: $310,047

State Funds	Federal Funds	Other
$109,401	$136,646	$64,000

Staffing: 17.2 FTE's

LEGAL DIVISION

Statutory Authority: Section 82A, RCM 1947

Description: The Legal Division represents the Department in all legal matters and provides legal opinions to the Bureaus of the Department on request.

Proposed Budget, FY 1979: $27,109

State Funds	Federal Funds
$27,109	0

Staffing: 7.5 FTE's

Board of Health and Environmental Sciences

Statutory Authority: Title 69, Chapter 1, RCM 1947

Description: The State Board of Health and Environmental Sciences is a seven-member Board appointed by the Governor to:

1. Advise the Department in public health matters.

2. Hold hearings on:

   a. Denial or cancellation of ambulance service licenses,
   b. Denial or cancellation of hospital or hospital-related facilities licenses,
   c. Disapproval of an application for construction of a health care facility.

3. Control air pollution by:

   a. Adopt rules and issue orders relating to air pollution.
   b. Classify air contaminant sources.
   c. Issue permits for equipment, etc., which might contribute to air pollution.
   d. Establish emission standards.
   e. Hold hearings on enforcement of air pollution standards.
   f. Hold hearings on emergency procedures used to control air pollution.
   g. Grant variances to air pollution standards.
   h. Regulate local air pollution control programs.
   i. Approve federal aid applications for local air pollution control programs.

4. Provide for occupational health by:

   a. Adopt rules and issue orders relating to industrial hygiene.
   b. Issue permits for equipment, etc., which might contribute to air pollution.
   c. Establish limitations on emissions of pollutants to prevent or control occupational diseases.
   d. Hold hearings on enforcement of industrial hygiene standards.
   e. Hold hearings on emergency procedures used to control industrial hygiene standards.
   f. Grant variances to industrial hygiene standards.
   g. Approve federal aid applications for industrial hygiene programs.

5. Control water pollution by:

   a. Hold hearings on denial, modification, suspension or revocation of permits relating to water pollution control.

b. Control state matching funds for construction of water pollution control facilities.
c. Establish water pollution standards and classification of water.
d. Hold hearings on establishment of water classification standards.
e. Hold hearings on enforcement of water pollution standards.
f. Hold hearings on emergency procedures used to control water pollution.

6. Have general supervision over public waters.

7. Direct disclosure of vital statistics information to other government agencies.

8. Hold hearings on granting, suspending, revoking or amending ionizing radiation licenses and hold hearings on emergency procedures taken to control radiation.

Proposed Budget, FY 1979: $8,000

State Funds	Federal Funds
$5,000	$3,000

DEPARTMENT OF INSTITUTIONS

ALCOHOL AND DRUG ABUSE DIVISION

Statutory Authority: 80-2701-80-2725

Description: The Alcohol and Drug Abuse Division is responsible for the general administration and coordination of two bureaus: Reporting and Evaluation and Community and Program Development.

Program Mission: The program mission of the Alcohol and Drug Abuse Division, as stated in the Executive Planning Process report, is "To provide and insure a means whereby the appropriate resources of the State of Montana are focused fully and effectively upon the problems of alcohol and drug dependence and utilized in implementing programs for the prevention, treatment, and control of these problems."

Goals and Objectives: Goals and Objectives provided by the Division in its Executive Planning Process report are as follows:

Planning & Funding

1. To provide a comprehensive and coordinated means of assessing the needs of Montana for substance abuse services and develop and implement activities to meet identified needs.
2. Develop uniform regional planning activities and prepare annual Plan for substance abuse.
3. Coordinate development and implementation of grants, contracts and plans necessary to further objectives of the Plan.
4. Improve coordination and cooperation among State social service agencies in support of substance abuse activities by developing agreements with other agencies for information exchange, planning and funding.
5. Utilize planning data to establish funding priorities and coordinate all Federal and State funding proposals relating to substance abuse and continue to fund 43 treatment programs.

Treatment

1. To continue to upgrade established substance abuse treatment and rehabilitation services in 43 statewide programs, including services in all State correctional facilities.
2. To encourage development of coordinated community, regional and statewide programs.
3. To provide services to approximately 8,000 alcohol abusers and 630 drug abusers in Fiscal Year 1978.
4. To continue administration of DWI Court Schools in cooperation with Department of Justice and Department of Community Affairs.

Prevention

1. To develop and refine substance abuse education available to the general public.
2. Develop substance abuse curricula for the public school systems. (K-12)
3. Develop effective methods of substance abuse prevention for use in public media by doing 2 statewide media campaigns; one for alcohol and one for drugs.
4. Assist communities, agencies, organizations and community programs in development of substance abuse prevention/education activities.

Training & Certification

1. To direct efforts toward insuring the passage of legislation for mandatory counselor certification in Montana and to certify 90% of substance abuse counselors on a voluntary basis in Fiscal Year 1979.
2. To provide 15 educational courses to 160 program staff including management, counselor and evaluation training in Fiscal Year 1979.

Technical Assistance

1. Provide technical assistance to 43 programs to assist programs in meeting State and Federal standards.
2. To develop and implement standardized statewide client record-keeping system.

Reporting & Evaluation

1. To maintain statewide computerized drug and alcohol management information systems.
2. To effectively utilize substance abuse data from other sources by expanding data collection techniques and data processing and analysis capabilities.
3. To provide 2 monthly data output reports for purposes of program planning, management and evaluation at local, regional and state levels.
4. To promote research studies pertaining to the causes and nature of substance abuse.

Approval & Evaluation

1. To conduct annual comprehensive on-site evaluation of 46 alcohol and drug programs, 3-4 days per evaluation, within the state to insure compliance with State and Federal Criteria.
2. To establish and update evaluation guidelines and procedures as set forth by law.
3. To approve 21 newly established alcohol programs in Fiscal Year 1979.

Substance abuse is a problem affecting the health, safety, morals, economy, and general welfare of approximately 8.5 percent of the general Montana population and 70 percent of the Native American population in Montana. In addition, all the indications of alcohol related accidents, and other indicators are showing increases; for example, the per capita consumption rate in Montana is showing an annual increase surpassed only by three other states.

The policy of Montana is to recognize alcohol and drug dependence as a health problem; to recognize alcohol and drug dependence as problems subject to treatment; and, to recognize the sufferer of alcohol, drug dependence, or both, as worthy of treatment and rehabilitation. The Alcohol and Drug Abuse Division's responsibility is to focus on appropriate resources pertaining to the problems of alcohol and drug dependence and to implement programs for control and treatment of these problems.

This is the first year that the Montana State Plan combined alcohol and drug programming processes. Prior to this, a plan for each system was written. Thus, the following program descriptions will present a brief overview of the two bureaus' functions combining alcohol and drug programs, prevention, treatment and rehabilitation. The program descriptions will include budget, evaluation methodology, and staffing patterns.

Community and Program Development Bureau

Description: The Bureau administers and coordinates the treatment and prevention of alcohol and drug abuse through regional and local programs. It provides technical assistance to programs for compliance ensurance of federal and state guidelines and assurance that goals and objectives are consistent with state policies for substance abuse services.

Because of the current hiring freeze, some of the Bureau's services may be in jeopardy due to the Division's inability to fill 23% (four positions) of key, resigned staff positions. Services without assigned staff are: Direct Services,Prevention, and one Training position which includes certification and standards--all of which are required by state and federal law.

The Bureau is responsible for the administration of the following services:

- --Direct Services
- --Technical Assistance
- --Special Services
- --Prevention
- --Training and Certification

Proposed Administration Budget, FY 1979:

State Funds	Federal Funds
$27,030	$26,846

Staffing: 1.75 FTE's

Direct Services

Description: The responsibility of this section of the Bureau is to administer the Southwest Montana Drug Program (SMDP). The Regional Office is located in Butte with satellite offices in Helena, Bozeman, Anaconda, and Missoula. Direct services are provided to a static capacity group of 293 drug abusers each month. Contracts for residential services are made with "Lighthouse" located at Galen.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$140,749	$386,386

Staffing: 16 FTE's

Technical Assistance

Description: This service provides technical assistance to all Montana alcohol and drug programs. After alcohol and drug programs have been evaluated and deficiencies are noted, technical assistance will be provided to help resolve weaknesses. Also, technical assistance will be provided in any area of specific need upon written request.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$26,915	-0-

Staffing: 1 FTE

Special Services

Description: The three basic components in Special Services are:

1. Employee Assistance Program
2. DWI Court Schools
3. Social Security Income (SSI) Program

Employee Assistance Program

Description: This program is for troubled state employees. The program offers counseling and referral services to state employees primarily in the Helena area; personnel from state agencies not residing in this area are referred to local community programs. Training and education is provided to directors of state agencies about alcohol and drug related problems and advantages of utilizing the program for troubled employees.

Of the 103 referrals made during September, 1977 - February, 1978, 45% were alcohol and/or drug related problems and 24% were emotional related problems. The remaining 31% of the referrals were related to financial, physical, marital, legal and unknown problems.

DWI Court Schools Program

The state office coordinates 22 DWI Court Schools throughout the state. Persons who had their driving licenses revoked must attend court school before provisional licenses are issued. During Fiscal Year 1978, 1,000 Montanans took advantage of this service.

Supplemental Security Income Program

The SSI Program is administered for persons eligible for SSI payments who are alcohol and/or drug abusers. Approximately 35 individuals were enrolled in the pilot project during Fiscal Year 1978.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$10,901	$18,963

Staffing: 2.25 FTE's

Prevention

Description: This service provides information to school children and the general public on issues relating to alcohol dependence and alcoholism, and treatment and rehabilitation services. It also contributes to the improvement for public accessibility into services.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$23,385	$52,385

Staffing: 1 FTE

Training and Certification

Description: The responsibility of the Training and Certification Component of the Bureau is to assist in the development of educational and training programs relative to alcohol and drug dependence, and to implement programs conducive to informing the public, technical and professional groups about alcohol and drug dependence.

A counselor certification system is being developed and will be implemented to ensure quality service to individuals seeking treatment in alcohol and drug programs.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$18,794	$61,069

Staffing: 3 FTE's

Prison Programs

Description: The Division and Bureau, in coordination with the Montana Board of Crime Control, will continue to assist in the support of substance abuse programs located within correctional institutions. Technical assistance will be provided to these programs. Since September, 1977, services have been provided to 73 residents.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$6,446	$49,450

Staffing: 1 FTE

2 contract FTE's

Evaluation and Reporting Bureau

The Bureau is responsible for program monitoring and evaluation management information systems, and the development of the annual state plan for alcohol and drugs.

It has three functional sections:

--Management Information Systems
--Contract, Monitor and Program Evaluation Section
--Planning/Policy Section

Proposed Administration Budget, FY 1979:

State Funds	Federal Funds
$39,909	$19,910

Staffing: 2 FTE's

Management Information Systems

Description: The Management Information Systems section is responsible for the maintenance of statewide computerized drug and alcohol data information. Substance abuse data from other sources will be effectively utilized to expand processing and analysis capabilities. Socio-economic and demographic data is provided regarding Montana's client treatment population for purposes of program planning, management, and evaluation.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$8,226	$27,726

Staffing: 1 FTE

Contract, Monitor and Program Evaluation

Description: The responsibility of this section is to conduct annual comprehensive evaluation of all alcohol and drug programs. The purpose for on-site program reviews is six-fold and is to:

--Improve program performance and client service levels.
--Help ensure statewide compliance with federal and state standards.
--Help achieve efficiency and economy in program operations.
--Assist in determination of program funding levels and approval of contracts.
--Determine areas of needed technical assistance and training.
--Gather data for development of additional standards for program performance.

Criteria for program review is based upon the procedures outlined in the Evaluation Handbook for Alcoholism Treatment, Drug Abuse and Community-Based Mental Health Programs developed by the Touche-Ross Consulting Firm.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$47,356	-0-

Staffing: 1 FTE

Planning/Policy

Description: This section of the Bureau is responsible for the provision of a comprehensive, coordinated means of assessing the human needs of Montana for substance abuse services and to implement activities to meet these needs. It also utilizes the planning data to establish funding priorities and coordinate all federal and state funding proposals relating to substance abuse. The Planning Section is responsible for development of the annual State Plan for Alcohol and Drug Abuse. The section also contracts for publication of the Division bi-monthly newsletter "The Habit".

Proposed Budget, FY 1979:

State Funds	Federal Funds
$23,583	$18,082

Staffing: 1 FTE

Administration

The responsibility of the Division Administrator, Bureau Chiefs, and support staff is to amend existing or initiate new legislation to further the objectives of the annual state plan. Also, they contract with substance abuse providers to ensure delivery of alcohol and drug services. Agreements will be developed with other human service agencies to improve coordination and cooperation and to exchange information, planning, and funding activities.

Proposed Budget, FY 1979:

State Funds	Federal Funds
$40,073	$27,909

Staffing: 6 FTE's

TOTAL PROPOSED BUDGET, FY 1979:

State Funds	Federal Funds
$413,367	$688,726

Total: $1,102,093

Staffing: 39 FTE's

MENTAL HEALTH AND RESIDENTIAL SERVICES DIVISION

Statutory Authority: Chapter 28, R.C.M. 1947; 80-24-2401, R.C.M. 1947; 80-2604, 38-12, R.C.M. 1947; 38-1101-1112, R.C.M. 1947; 80-1701-80-1705, R.C.M. 1947; 82A-801.1, R.C.M. 1947; 80-2310, R.C.M. 1947; 80-1401, R.C.M. 1947.

Program Mission: The Program Mission of the Mental Health and Residential Services Division, as stated in the Executive Planning Process report, is "To rededicate the resources of the State to the productive independence of its now dependent citizens and to promote and maintain the general well-being and mental health of the citizens of the State."

Goals and Objectives: The Goals and Objectives provided by the Division in its Executive Planning Process report are as follows:

a. To provide those mental health services mandated by P.L. 95-83 to all citizens of Montana.
b. To make available appropriate aftercare support services to all former WSSH patients.
c. To sustain the development of improved treatment programs within all institutions.
d. To develop standards of care and treatment for state institutions and CMHC's and to provide biannual program and fiscal audits of the five CMHC's and at least annual evaluations of each institution under the jurisdiction of this Division.
e. To continue appropriate deinstitutionalization of mentally ill and developmentally disabled.
f. To develop appropriate residential treatment alternatives for the Children's Unit at WSSH.
g. To coordinate planning for mental health services based upon statewide needs assessment, and development of a State Mental Health Plan.
h. To continue refinement of systems to facilitate the orderly intra- and interstate transfer of patients.
i. To continue to serve as a clearinghouse for CMHC's and institutions for relevant information concerning current clinical and management information as well as available grant funds.

The following narrative will describe the Division's responsibility relative to mental health programs along three functional lines--planning, operations and evaluation.

Operations Section

Description: The Division of Mental Health and Residential Services is responsible for the administration and supervision of the Montana mental health program including community-based services and institutionally-based services. In this capacity, the Division maintains the authority and responsibility for preparation of the State Mental Health Services Plan as well as the ongoing achievement monitoring of program objectives. Further, the Division is accountable to the Federal Government for correct expenditures of federal funds received for mental health administration and program operations under Section 314(d) of the Public Health Services Act and for expenditures under Section 227 (c) of the Act. Recommendations for allocation of state funds shall be made by the Division based on assessment of mental health needs and performance of CMHC mental health programs.

The Division is responsible for administration and supervision of six institutions. They are: institutionally based services for the mentally ill at Warm Springs State Hospital; institutional services for geriatrics at the Center for the Aged; Services to Montana's veterans at the Veteran's Home; institutional services for the developmentally disabled at Boulder River School and Hospital and Eastmont Training Center; and institutional services for alcoholics and individuals with respiratory diseases at Galen State Hospital.

While administration and supervision of the institutional programs are maintained by the Division, provision of community-based programs for the mentally ill has been contracted for through the regional Community Mental Health Center Boards. Additionally, community mental health services may by provided for directly by other state agencies or indirectly through contract or cooperative agreement with other agencies of government, regional or local, private or public agencies, private professional persons or hospitals, under rules adopted by the Department of Institutions as described in Section 80-2803 (1), R.C.M. 1947.

Major categorical responsibilities of the Division regarding the five regional Community Mental Health Centers and their Thirty (30) satellites are as follows.

Description: The Division facilitates the coordination with five regional mental health boards. The State mental health authority is required to insure prevention of mental illness and elimination of inappropriate institutionalization through statewide supervision of federally required services. Approximately 15-20 percent of the CMHC's budgets is used for consultation and education--those services which help insure prevention of mental illness, eliminate the stigma attached to mental illness, and to educate the public about available resources. The subsequent sections explain how the responsibilities of the Division are categorized.

Planning Section

The State Plan shall be prepared and maintained by the Division. It must be based on an assessment of needs and resources and must have an annual review and plan revisions to be in compliance with P.L. 95-83.

The Division is required to prescribe and provide minimum Standards for Maintenance and Operation of mental health programs and facilities including community mental health centers.

Evaluation Section

Evaluation will include but is not limited to:

1. determination of compliance with standards including enactment of legally enforceable penalties for noncompliance;
2. performance of administrative appeals of enforcement actions;
3. performance of periodic review and revision of standards at least every five years;
4. publication of proposed modifications to existing standards for review and comment at least 30 days prior to adoption; and
5. preparation of reports to the United States National Institute of Mental Health about the nature and degree of program deficiencies. Reports will include status of enforcement action of noncompliance with established standards for projects approved under the Community Mental Health Centers Act.

Special Projects

Two special units within the Mental Health and Residential Services Division are the Community Support Project (CSP) and the Manpower Project. Both programs have been funded with federal monies.

The CSP's mission is to develop a system of community-based services for the severly mentally disordered adult. A model is being developed in the South Central Mental Health Center, will be validated in another center, and replicated throughout Montana.

The Manpower Project's mission is to marshall the resources, harness the commitment and enthusiasm, and improve the capacity of the mental health system in Montana to respond to all the multi-faceted mental health manpower issues. Achievement will improve service delivery and assure a strong and continued coordinated effort toward a comprehensive manpower system with positive linkages between and among all the diverse components of the state mental health system.

In addition, an intensive effort will be made to educate the general public by influencing other than patient populations, prevention of mental illness and promotion of mental health, and highlighting those community mental health problems which are better approached through changing environmental conditions and through clinical methodologies.

Proposed Budget, FY 1979:

	State Funds		Federal Funds	FTE's
Division	$ 153,615		$ -0-	6
Projects				
Community Services	-0-		83,800	7
Manpower	-0-		110,000	7
Mental Health Centers	2,938,347	approx.	1,600,000	266
Institutions				
WSSH	11,885,855	approx.	254,756	680
BRSH	6,906,673		261,327	598
Center for the Aged	1,426,692		-0-	94
Eastmont	450,600		53,170	32
Galen	3,949,486		706	260
Veteran's Home	156,944		624,098	49
				1,999

DEPARTMENT OF LABOR AND INDUSTRY

Safety and Health Bureau

Statutory Authority: Title 41, Chapter 17, Title 50, Chapters 1 & 4, Title 69, Chapters 15 & 16.

Description: The Safety and Health Bureau conducts safety inspections of employers in mining, logging, and public agencies and inspects and approves the operation of boilers. Using the Federal Occupational Safety and Health Standards, the program conducts advisory inspections for other employers, licenses boilers and crane operators, certifies coal mine foremen, and conducts safety and health training programs in first aid, CPR, defensive driving and general safety.

Program Mission: To promote the safety and health of the State's workers.

Goals and Objectives: The current goals and objectives of the Bureau, as stated in its Executive Planning Process report, are:

a. According to State Statute:

   1. To conduct approximately 600 mandatory inspections to insure safe working conditions.

   2. To inspect or review the inspections of approximately 3,000 boilers per year.

   3. To examine and certify coal mine foremen.

   4. To perform approximately 750 mining inspections and training courses per year.

   5. To examine and license all boiler and crane operators.

b. To perform accident investigations on all fatal and serious accidents at the above work places.

c. To conduct approximately 600 advisory inspections during the year.

d. To assist employers in establishing safe working conditions through various training activities and personal contacts.

e. To follow up complaints received relative to unsafe working conditions.

Proposed Budget, FY 1979: $655,946

State Funds	Federal Funds
$631,372	$24,574

Staffing: 28 FTE's

OFFICE OF PUBLIC INSTRUCTION

OFFICE OF PUBLIC INSTRUCTION

Statutory Authority: Title 75, Chapter 57, R.C.M. 1947; 75-5704

The Office of Public Instruction is divided into four departments: Financial Services, Vocational and Occupational Services, Administrative Services and Basic Instructional Services. Within the Basic Instructional Services Department are three units: Basic Skills, Special Education and Federal Programs. Within the Basic Skills Unit is the Consultative Services Division which supervises the activities of the Health and Physical Education Consultant.

Program Mission: The program mission of the Health and Physical Education Consultant, as stated in the Executive Planning Process report is, "To carry out the goals and objectives of the State Superintendent of Public Instruction."

Goals and Objectives: The goals and objectives provided by the EPP report are as follows:

a. To provide educational experiences essential for individual freedom and growth.
b. To encourage the continuous preservation and development of a free society.
c. To develop insofar as possible the greatest potential in its citizens through access to educational opportunities.
d. To encourage the preservation of cultural and environmental heritage.
e. To provide comprehensive and responsible educational leadership.
f. To provide services to the various components of education.
g. To promote educational opportunities for Montana citizens.
h. To encourage lay and professional persons and associations to contribute to the educational decision making process.
i. To assist and cooperate with the public, governmental agencies, school districts, educational organizations and elected officials in developing and maintaining quality education.
j. To be responsive to the changing educational needs as perceived by this office and to suggestions and requests as expressed by the citizens of this state.
k. To provide program, personnel and financial accountability to the citizens of this state.
l. To continually inform the citizens of this state of the status of educational achievements, needs and considerations.
m. To pursue cost saving methods while maintaining effective and efficient delivery of educational services.
n. To coordinate programs, activities and personnel to achieve an equitable balance among all educational endeavors.
o. To plan a fiscal and activity program for present and future educational needs and direction.
p. To uphold and obey all federal and state laws and initiate and/or advocate modification when necessary.

Basic Instructional Services Program (health education)

Description: The office function is to assist local school districts, Office of Public Instruction programs, state agencies and units of higher education in diagnosing, prescribing and promoting health and physical education which will develop the full potential of each leader. General responsibilities are to provide consultative and technical services that aid in the development, formation and implementation of creative health and physical education programs; develop resource information to serve the needs of Montana educational personnel; to administer the programs of health and physical education and to evaluate the programs of health and physical education in schools.

Duties that are specific to health education include:

1. Assist school personnel in developing and implementing goals and objectives;
2. Participate in Northwest Regional Accreditation Evaluations and make recommendations in the area of health education;
3. Conduct on-site evaluations of school health education programs for the purpose of diagnosing, prescribing and recommending to school districts, boards of education, superintendents and administrators for needed improvements and changes to improve the quality of education in that particular district;
4. Provide inservice training in the area of health to bring updated information and new ideas to teachers;
5. Provide assistance in planning, organizing and conducting workshops and conferences on health education topics;
6. Provide consultative services in curriculum design and implementation in health;
7. Provide resource materials to schools;
8. Work with related health agencies and organizations to provide more and better services to schools.

Proposed Budget: $7,000

Staffing: 1½ FTE's

DEPARTMENT OF SOCIAL
AND
REHABILITATION SERVICES

COMMUNITY SERVICES DIVISION

Statutory Authority: Sections 10-501, 507, 509, 510, 520, 521, 522, 524, 611, 703, 802-807; 71-1516, 1914-1919, 2303, 2307; 82A-102, 4203; 71-201-270; 82A-1901-1906; 61-302-326; 10-1300-1322, 1400-1409, 1207; ARM-46-2.6(2)-5640; 46-2.6(2)-5650; 46-2.6(2)-5660.

The Older Americans Act of 1965 as amended; Title III, Title IV-A, Title V and Title VII: and Title XX of the Social Security Act.

82A-1901 R.C.M. 1947; 71-701 to 714; MAC 56470 Chapter 10.

Description: This Division is responsible for the overall administration of three bureaus: Aging Services, Social Services, and Child and Youth Development. These bureaus, in turn, administer the direct services program.

Goals and Objectives: The Goals and Objectives will be shown below each bureau description.

Aging Services Bureau

Statutory Authority: The Older Americans Act of 1965 as amended Title III, Title IV-A, Title V, Title VII and Title XX of the Social Security Act.

Description: The purpose of the Bureau is to promote independent living and, thus, the dignity of Montana's senior citizens.

The major programs of the Bureau are funded under the Older Americans Act of 1965. Under Title III of the Act, the Bureau is responsible for distributing block grants to Montana's seven Area Councils on Aging, and for approving annual plans submitted by the area councils. Title III funds are distributed to the area councils in proportion to the number of persons over 55 years of age who reside in each of the planning and service areas. The area councils use these funds to support local senior citizen organizations that provide direct services such as transportation, senior centers, outreach, information and referral, and health services.

Title III programs and services are available to all Montanans 55 years and older, and Title VII programs and services are available to persons 60 years and older. Both Title III and Title VII programs and services are available to all American Indians 45 years and older who desire or are in need of these services.

Program Mission: To maximize the independent living situations of Montana's Senior Citizen population.

Goals and Objectives: Goals and Objectives provided by the Division in its Executive Planning Process report are as follows:

(1) To standardize contracts used by Title VII projects by September 30, 1979.
(2) To reduce the home-delivered meals serviced by Title VII to a statewide percentage of 25% by September 30, 1979.
(3) The Aging Services Bureau, through the Aging Services Network, will conduct a survey of all senior citizens centers statewide by September 30, 1979.
(4) Survey recipients of all Older Americans Act service projects to determine percentage of participation by low-income and minority senior citizens by September 30, 1979.
(5) Involve the Aging Services Network of Montana in an accelerated program to increase the effectiveness and coordination of all Human Service Programs at community, county and PSA levels by September 30, 1979.
(6) To improve the availability of in-home services to residents of senior and low-income housing projects by September 30, 1979.

(7) To implement a formal agreement with the Montana Nursing Home Association by September 30, 1979.
(8) Co-sponsor a contest within the public school system designed to counteract the early development of negative stereotypes about older persons by September 30, 1979.
(9) Expand monthly Information and Referral report to include consumer watch information by May 31, 1979.
(10) Increase the in-house management capabilities of Title VII projects by September 30, 1979.

Proposed Administration Budget, FY 1979:

State Funds	Federal Funds
-0-	$200,000

Staffing: 15 FTE's

1. Title III: Grants for State and Community Programs on Aging.

Statutory Authority: Title III of the Older Americans Act of 1965 as amended.

Description: To establish and maintain a comprehensive coordinated system designed to facilitate accessibility and utilization of social services and to initiate and develop and make the most effective use of social services in meeting the needs of older persons in the community.

Proposed Budget, FY 1979:
(Includes Program and Administration of 7 area agencies)

State Funds	Federal Funds
-0-	$757,350

2. Title IV-A: Training Grant

Description: Training will be provided to improve the quality of services for the aged and to help reduce critical shortages of adequately trained personnel for programs in the field of aging by providing direct training to personnel of the Aging Services Bureau, Area Agency on Aging, and those individuals that work directly with aging programs at the local level.

Proposed Budget, FY 1979:

	Federal Funds
Contracted Training	$20,000
Direct Training	10,000
Total	$30,000

3. Title V: Multipurpose Senior Citizens Center Grants

Description: To administer funding for Senior Citizens' Centers.

Proposed Budget, FY 1979:
(Seven area agencies)

State Funds	Federal Funds
-0-	$200,000

4. Title VII: Nutrition Program for the Elderly

Description: To assist in meeting the nutritional needs of America's citizens that are sixty years of age and older. The program provides permanent nutrition projects and the supportive services to insure maximum effectiveness of the meals provided.

Proposed Budget, FY 1979:

Title VII Project	Federal Funds
Smelter City Senior Citizen's Title VII Nutrition Project Anaconda, Mt. 59711	$ 86,991
Yellowstone County Nutrition Project Billings, Mt. 59101	218,770
Butte Senior Citizen's Diners Club Butte, Mt. 59701	99,815
Title VII Nutrition Project Glendive, Mt. 59330	164,364
Cascade County Title VII Nutrition Project Great Falls, Mt. 59401	123,475
Hill County Council on Aging Senior Nutrition Project Havre, Mt. 59501	187,625
Tri-County Senior Citizens Helena, Mt. 59601	140,397
Flathead Title VII Nutrition Project Kalispell, Mt. 59901	216,063
Total	$1,237,500

5. Nursing Home Ombudsperson Project

Description: This is a statewide network, in cooperation with existing information and referral technicians, who will be in contact with all nursing homes and will provide grievance procedures to all staff and clients of these establishments.

Proposed Budget, FY 1979:

State Funds	Federal Funds
-0-	$18,000

6. Administration on Aging, Legal Services Grant

Description: Provision of legal services will be made to the senior citizens of Montana. The entire amount is to be contracted with Montana Legal Services Association for the services. The grant will also be used for the following:

a. Determine high incidence legal problems that occur among senior citizens.
b. Determine which high incidence areas should receive special attention and develop methods of approach to ease the handling of such problems.
c. Disseminate developed materials to all appropriate and/or concerned individuals.
d. Assist the Aging Services network with the development and expansion of paralegal and legal services to the seniors of Montana.

Proposed Budget, FY 1979:

State Funds	Federal Funds
-0-	$26,800

7. Title XX: Services

Description: Six of the seven Area Agencies will provide Nutrition, Homemaker/Chore, Transportation, and Minor Home Repair Services to senior citizens who qualify under the eligibility guidelines for Title XX. A brief description of each service will follow.

Nutrition Services

Description: Nutrition services include the provision of nourishing congregate meals in a community setting and the preparation and delivery of nourishing meals to the homes of senior citizens who are unable to obtain or prepare them. The program will provide less than three meals per day and is not designed to meet full nutritional needs of the individual.

Proposed Budget, FY 1979:

State Funds	Federal Funds	Local Funds
-0-	$258,983	$86,328

Homemaker-Chore

Description: Homemaker-chore services include home management, home maintenance and limited personal care services to be provided by privately contracted and supervised homemakers to senior citizens in order to maintain independent living situations in their community and to prevent premature institutionalization.

Proposed Budget, FY 1979:

State Funds	Federal Funds	Local Funds
-0-	$123,466	$41,155

Transportation for Senior Citizens Program

Description: Transportation services for senior citizens will include reduced fares on available public transportation; volunteer drivers reimbursed for mileage and scheduled and unscheduled bus and van and limousine services. The program will provide transportation to medical facilities and services, shopping centers, social events, senior centers and other community facilities and resources and will prevent institutionalization and maintain independent living situations.

Proposed Budget, FY 1979:

State Funds	Federal Funds	Local Funds
-0-	$85,313	$28,438

Minor Housing Repair Program

Description: Housing repair services will be provided senior citizens who are home owners. The program includes correction of structural flaws such as doors, steps, handrails, roofs, insulation, storm windows and other weatherization projects; the repair of furnaces and water systems.

Proposed Budget, FY 1979:

State Funds	Federal Funds	Local Funds
-0-	$55,238	$18,412

Aging Services Evaluation:

1. Evaluation of the effectiveness of the contractual arrangements to form Title VII projects.

2. Evaluation of the progress of projects in reducing the percentage of home delivered meals.

3. Evaluation of the effectiveness of provision of in-home services to residents in housing projects.

4. Evaluation of the agreement with the Montana Nursing Home Association and evaluation of the deinstitutionalization process.

5. Evaluation of the information and referral network.

6. Evaluation of the management of the Major Initiative Tracking System.

Child and Youth Development Bureau

Statutory Authority: 82A-1901 R.C.M. 1947; 71-701 to 714; MAC 56470 Chapter 10.

Description: The purpose of this Bureau is to prevent, reduce or correct problems of the youth of Montana in order to provide a better quality of life for the youth and citizens of the State.

Program Mission: The program mission, as cited in the Executive Planning Program is, "To prevent or reduce problems of Montana youth who are defined in Montana Youth Court Act as Delinquent, Youth in Need of Supervision and Youth in Need of Care, or those youth who are in danger of becoming the above."

Goals and Objectives: Goals and Objectives provided by the Division in its Executive Planning Process report are as follows:

a. To reduce and prevent an increase of "Youth in Need of Care" on child welfare caseloads and to reduce and prevent an increase of "Youth in Need of Supervision" on child welfare and probation caseloads.

(1) To teach behavior management and social learning skills to 140 families (involving 280 children aged 5-12) in Lewis and Clark County in order to reduce potential abuse, neglect and exploitation in FY 1978-79 and to teach behavior management and social learning skills to 200 families (involving 400 children aged 5-17) in Lewis and Clark County in order to reduce potential abuse, neglect, and exploitation in FY 80-81.

(2) To train 10 child welfare case workers in a program of behavior management and social learning skills, for use with protective service families in order to reduce potential abuse, neglect and exploitation in FY 78-79 and to train 50 child welfare case workers in a program of behavior management and social learning skills, for use with protective service families in order to reduce potential abuse, neglect and exploitation in FY 80-81.

(3) To improve the home and school behavior and school performance of 850 youth primarily from single parent families through providing a one-to-one adult relationship in FY 78-79 and to improve the home and school performance of 1,200 youth primarily from single parent families through providing a one-to-one adult relationship in FY 80-81.

(4) For 45 youth served at Achievement Place to reunite 40 percent with their natural families and to place 35 percent in a suitable alternative placement such as a group or foster home or independent living when return to natural family is not feasible in FY 78-79 and for FY 80-81 to serve 65 youth with 60 percent returning home and 35 percent in suitable alternative placements.

(5) For 500 youth served by Runaway projects to successfully reunite 50 percent with their natural families and to place 40 percent in a suitable alternative living situation in FY 78-79. For 600 youth served by Runaway Projects in FY80-81 to reunite 60 percent with natural families and place 30 percent in a suitable alternative.

(6) To develop two shelter care programs in FY 78-79 and four in FY 80-81 serving approximately 250 youth (FY 78-79) and 450 youth (FY 80-81) referred from Social Services and Probation. The overall shelter care program is designed to achieve a 75 percent of 1,700 youth reduction in status offenders detained in secure lock-up facilities.

(7) To design and implement three comprehensive intake programs designed to divert 400 status offender youth (FY 78) and 1,000 status offender youth (FY 79) from the Juvenile Justice System in FY 78-79 and to design and implement seven comprehensive intake programs designed to divert 600 status offender youth (FY 80) and 1,400 status offender youth (FY 81) from the Juvenile Justice System in FY 80-81.

(8) To increase the supportive services available for families experiencing problems by 10 percent in 1978-79 and by 15 percent in 1980-81 through development of programs, i.e.,: Parents Anonymous, Lay Therapists, Comprehensive Emergency Services, Parent Aides.

(9) To increase the services available for children experiencing problems by 10 percent in 1978-79 and by 15 percent in 1980-81 through provision of services, i.e.: foster home/crisis day care recruitment and training, coordination of service providers (child teams).

(10) To increase the awareness level of the public to the needs of children and to the services available for children by 10 percent in 1978-79 and by 12 percent in 1980-81 through public awareness programs, i.e.: regular newspaper articles, presentations to service clubs and community organizations, training of WIN parents.

(11) To increase the ability of service providers and funding agencies/organization to address the needs of children by increasing their available data on children by 20 percent in 1978-79 in seven communities and by 20 percent in 1980-81 in nine communities by research and presenting data to providers/funders, evaluating funding requests.

(12) To increase the number of programs which divert children and youth from undesirable actions by 30 percent in 1978-79 and by 40 percent in 1980-81 through development of programs, i.e.: after school care, summer enrichment.

(13) To train 400 foster parents in 1978-79-80-81, through providing 36 workshops in 1978-79 and 40 workshops in 1980-81 sponsored by the Montana State Foster Parents Organization.

1. Youth Development Program

Description: The Bureau's primary Youth Development Program is directed toward helping youths who have committed anti-social acts; especially runaways, status offenders, low-income youths, and those in need of protection. The Bureau uses funds received under Title XX and the Runaway Youth Act to contract with local non-profit organizations to provide services such as shelter, room and board, group care, volunteer services, runaway networkings, counseling and recreational activities. While Bureau staff members do not provide any direct services to youth, they are continuously involved in community organization, planning technical assistance, and working with other agencies, organizations, and local officials to promote a more effective and systematic approach to solving the problems of youth people.

2. Child Development Service

Statutory Authority: Montana Administrative Code, Volume 8, Part 1, Subchapter 10, Title 46-2.6 (10) 56520-56640.

Description: The Child Development activity package is designed to provide support services to child care and other children's programs. Local non-profit child care corporations (4-C's) are contracted with to provide planning and program development for children's services, involving coordination of local agencies and programs. The community's child-serving system is the primary area of emphasis. Some programs developed include: Parents Anonymous, Comprehensive Emergency Services, After School Care, parent aide and lay therapist programs to reduce problems of child abuse and neglect. Coordination of community services has been provided by: developing coalitions of providers for planning, 4-C Boards equally composed of public and private service providers and consumers, needs assessments and comprehensive planning, providing input to community planners on social services, ad hoc and standing committees and task forces. 4-C's also provide recruitment and orientation for day care operators, training for child care providers and educators on early detection of handicaps and possible abuse or neglect and parent and child development training.

Proposed Budget, FY 1979:

	State Funds	Federal Funds	Third Party
	$57,686	$239,552	$30,020

Total $327,258

3. Youth Development Service

Statutory Authority: Montana Administrative Code, Volume 8 Part II, Subchapter 10, Title 46-2.6 (10) 56520-56640.

Description: The Youth Development activity package is designed to prevent or reduce problems of Montana youth who are defined in the Montana Youth Court Act as Delinquent, Youth in Need of Supervision, and Youth in Need of Care, or those youth who are in danger of becoming the above. The activity package is aimed at improving the delivery of Montana governmental and private services for problem youth and at coordination of Montana's youth services. This includes Federal, State and local public and private resources. Youth Development provides services to communities and local agencies and does not work directly with individual clients. Major functions are Planning and Program Development. The community's youth service system is the primary area of emphasis. Direct services are provided through "Purchase of Service" contracts with local non-profit corporations and units of local government. These contracts include: group home treatment programs, Big Brothers/Big Sisters and Runaway Youth Programs. Services offer support to the youth and concentrate on serving the complete family unit. This activity package relies heavily upon a signed Joint Cooperative Agreement with the Montana Board of Control (MBCC) wherein the Department of SRS and MBCC agree to share staff under the guidance and program direction of the Montana Youth Justice Council.

Proposed Budget, FY 1979:

	State Funds	Federal Funds	Third Party
	$64,889	$173,220	$1,481

Total $239,590

4. Social Learning Program

Statutory Authority: Montana Administrative Code, Volume 8 Part II, Subchapter 10, Title 46-2.6 (10) 56320-56640.

Description: The Social Learning activity package is a community-based treatment program using a behavior management/social learning treatment modality. It is provided as an alternative to institutions for youth and to treat families and youth in the least restrictive environment. The program includes four group homes and a non-residential Family Treatment Center. The homes and the center are geared toward teaching youth socially acceptable behavior and teaching the youth's parents some parenting skills. Youth and families are usually involved with the program from six to nine months.

The increasing number of new private and public agencies serving children and youth in need will influence the existing operation of services to Youth in Need of Care. County Welfare officers will be able to provide better services through referral and follow-up. Continued deinstitutionalizing of status offenders (curfew violation, runaway, incorrigible, etc.) could have an effect upon this activity.

The increasing number of youth who are being referred to community-based treatment homes instead of detention facilities and the availability of treatment to children and families at home indicate past effectiveness. Promote the availability of more alternative types of care facilities for young people in need with an emphasis upon services being provided in the least restrictive environment possible.

Proposed Budget, FY 1979:

	State Funds	Federal Funds
	$63,500	$190,500
Total	$254,000	

5. Volunteer Program

Statutory Authority: Montana Administrative Code, Volume 8, Part II, Subchapter 10, Title 46-2.6 (10) 56520-56640.

Description: This activity purchases support to volunteers to children and youth. The volunteer is matched with the youngster and provides companionship and, in some cases, a role model for the child. It is aimed at children from single parent families who could benefit from the adult volunteer services. These services help divert the child or youth from getting into trouble and are aimed at improving his or her performance at home and in school. Most requests for services come from either the family or the school.

Proposed Budget, FY 1979:

	State Funds	Federal Funds	Third Party
	-0-	$123,750	$41,250

Total $165,000

6. Runaway Youth Program

Statutory Authority: Montana Administrative Code, Volume 8 Part II, Subchapter 10, Title 46-2.6 (10) 56520-56640.

Description: The Runaway Youth activity package focuses on meeting the immediate needs of youth in crisis. It provides the youth immediate guidance and assistance during the crisis situation, and reunites them with their families when possible. Contracts are written with local corporations in high risk areas to provide emergency shelter, food, counseling, information and referral, legal and medical assistance, transportation and case follow-up. The program is designed to assist the young person through a traumatic period of time by providing emergency care outside the juvenile justice system, thereby reducing the case load of the juvenile justice system and preventing the attachment of a stigma to the youth in crisis.

Proposed Budget, FY 1979:

	State Funds	Federal Funds
	$8,750	$56,250

Total $65,000

7. Foster Parents Program

Statutory Authority: Montana Administrative Code, Volume 8, Part II, Subchapter 10, Title 46-2.6 (10) 56520-56640.

Description: The Montana State Foster Parents Organization has contracted with the Bureau for the training of licensed foster parents. All participation in organizational activities is volunteered on the foster parent's part. The organization has brought together over 400 foster parents each year. Training in parenting skills is provided with input and participation from foster parents. Through these training sessions foster parents are able to benefit from sharing experiences and problems. This is a valuable asset in the retention and satisfaction of good foster homes. Foster parents accept and promote programs in cooperation with social workers through the awareness and training provided through the activity. MSFPO provides assistance and organizational skills, too, to local foster parent associations.

Proposed Budget, FY 1979:

	State Funds	Federal Funds
	$8,322	$29,678

Total $38,000

Staffing: 17.25 FTE's

Evaluation:

1. Increased awareness by providers of licensing laws and standards expanded availability of 24-hour a day care services on an emergency basis, and increased coordination of community services to families with the potential for child abuse and neglect.

2. Direct reduction in the number of status offenders (truants, incorrigibles, and runaways) held in jail, reduction in the number of status offenders in institutions, establishment of restitution programs for vandalism and burglary, and establishing cooperative working agreements between C&YCB, Board of Crime Control, Department of Institutions, and OPI.

3. Increased the number of youth who are being referred to community-based treatment homes, and increase the availability of treatment to children and families at home.

4. Developing an assessment form for Big Brothers and Big Sisters Programs.

5. Provide emergency treatment to prevent the involvement of runaways with the criminal justice system.

Social Services Bureau

Statutory Authority: Sections 10-501, 507, 509, 510, 520, 521, 522, 524, 611, 703, 802-807; 71-1516, 1914-1919, 2303, 2307; 82A-102, 4203; 71-201-270; 82A-1901-1906; 61-302-326; 10-1300-1322, 1400-1409, 1207; ARM - 46-2.6(2), 5640; 46-2.6(2), 5650; 46-2.6(2) 5660.

Description: The purpose of the Social Services Bureau is to promote self-sufficiency, protect adults and children, assist individuals in self-support, prevent inappropriate institutionalization and place persons into institutions when appropriate. The Bureau employs five persons at the bureau level, and has supervisory authority over about 250 social workers, homemakers, and social service aides located in district and county offices statewide.

Program Mission: To maintain and strengthen families through comprehensive services to children and families and to provide services to adults to assist their living in the least restrictive setting.

Goals and Objectives: Goals and Objectives provided by the Division in its Executive Planning Process report are as follows:

a. To maintain children in their own homes or in the least restrictive environment.

   (1) To continue to develop, provide and maintain quality child-centered, family-focused protective services to 7,500 children who are abused, neglected and/or exploited and to seek referrals and provide investigation of all children alleged to be neglected with an estimated increase to 8,250 children in FY 1980-81.
   (2) To provide homemaker services to 250 families in order to protect children from possible abuse or neglect in FY 78-79 and to increase homemaker services to 350 families in FY 80-81.
   (3) To continue to develop a system to insure quality day care to 1,500 children so that parents may engage in or seek employment or training and to 208 children in danger of neglect, exploitation or abuse.
   (4) To develop and implement a sliding scale day care payment system for children whose parents have incomes within 58% of the state medium income and to increase the rates paid to day care providers in FY 80-81.
   (5) To provide case management services to 100 developmentally disabled children in FY 78-79 and to increase the number of case management services to 250 children in FY 80-81.
   (6) To continue to provide 4,140 children with early medical screening and health related services.

b. To provide alternative temporary placement for children when necessary and permanent placement when appropriate.

(1) To continue to provide the best possible foster care placement to 1,512 children and families in need of substitute care by developing criteria for placement, developing the service plan and using appropriate resources.
(2) To continue to provide community-based services for 100 children placed in institutional settings.
(3) To provide the best possible placement for each child and family in need of substitute care and reduce the foster care caseload by 100 children in FY 80-81.
(4) To continue to assure that 150 children free for adoption can be placed with an appropriate family in Montana and to provide for the evaluation of 816 non-agency placements as required by law.
(5) To provide subsidized adoption for 40 children with special needs and who would otherwise not be adopted; 20 children with a monetary subsidy including sibling groups, and 20 children in need of a medical subsidy in FY 78-79 and to provide for subsidized adoption of an additional 40 children with special needs who would otherwise not be adopted; 20 with a monetary subsidy and 20 with a medical subsidy, for a total of 80 children in FY 80-81.

c. To provide social services to adults in need which will assist them to remain in their own homes or when necessary to plan and provide for alternate living arrangements. (Governor's Policy Initiatives, p. 27, last paragraph; p. 28, paragraphs 2 and 4; p. 29, paragraphs 1 and 2 under Aging Services.)

(1) To continue to provide protection to 2,280 adults unable to protect their own interest by identifying, investigating and providing counseling, arranging alternative living arrangements and other services to prevent abuse, neglect or exploitation.
(2) To provide homemaker services to 703 adults to assist them to remain in their own homes in FY 78-79 and to serve an additional 200 adults in FY 80-81.
(3) To continue to provide foster care and other services to 714 adults, to recruit and evaluate homes for 300 individuals in order to prevent institutionalization.
(4) To provide case management for 1,250 adults who are developmentally disabled in FY 78-79 and to provide case management through Individual Habilitation Planning to 1,350 adults in FY 80-81.
(5) To continue to provide health related services to 1,692 adults in order to prevent dependency and institutionalization.
(6) To serve 1,117 residents in long-term care facilities, including counseling for entrance into and discharge planning from these facilities in FY 78-79 and to serve 3,589 residents, including developing and implementing policies related to entrance and discharge planning in FY 80-81.

d. To provide community-based services to enhance self-sufficiency.

(1) To continue to provide information and referral services to 8,865 persons upon request, and to provide follow-up in order to assure appropriate provision of services.
(2) To continue to enable 1,330 low-income persons to obtain legal services for problems which impede the achievement or maintenance of economic self-support and self-sufficiency and the prevention or remediation of neglect, abuse or exploitation.
(3) To continue to provide comprehensive family planning services to 3,000 persons in order to enable them to voluntarily limit the size of their families.

e. To provide WIN services in order to reduce dependency. (Governor's Policy Initiatives, p. 29, paragraph 2.)

(1) To continue to provide social services in single administrative unit teams in cooperation with staff from Employment Services Department of Labor and Industry to 1,500 individuals in order to facilitate participation in employment or training.

1. Adoptive Program

Description: Adoption services include provision of social services as a protective service to enable appropriate children to be placed in adoptive homes and to provide for the evaluation of non-agency adoptive placements as required by law. Services of this program include initial evaluation, direct evaluation, post and pre-counseling, placement of child, follow-up services, follow-up evaluation, and recruitment of and/or approval of adoptive homes.

2. Day Care for Children Program

Description: This program provides organized services for the direct supplemental care of children away from the child's home, for a portion of a 24-hour day. Monitoring, pre-placement visits and periodic evaluations are provided as they relate to the specific child to meet his/her needs. Meals are provided but less than three meals per day.

3. Family Planning Program

Description: Family planning services are comprehensive services directed primarily at preventive health measures and counseling that are aimed at enabling families to voluntarily limit their family size. Family planning services include counseling, patient education, blood tests for anemia, rubella, and syphilis; immunization for rubella, blood pressure, height and weight, physical examinations, pap smear, gonorrhea culture, gonorrhea treatment, pregnancy tests, urine analysis for sugar and protein, breast self-examination instruction, diagnosis and treatment of vaginal infection, I.U.D. insertion, dispensation of contraceptive supplies, inter-agency referral for other problems, and day care and transportation services when needed. AFDC clients are served through Title XIX.

4. Foster Care for Adults Program

Description: This program promotes and secures foster care in foster and group homes. These services are available to persons age 18 and over who are unable to remain in independent living situations. Also included are persons in institutions who need community placement by providing counseling services to adults upon the initiation or termination of placement. An evaluation assessment of client needs is provided by a process of counseling, recruiting, evaluating and licensing adult foster homes and community homes for the developmentally disabled.

5. Foster Care for Children Program

Description: To provide foster care services for children under age 18 outside their homes for more than 24 hours when their own homes are not available to them. Activities of the program include:

1. Preparatory services to children and families upon initiation or termination of foster care placement.
2. Recruitment, evaluation, and licensing of foster group homes and institutions as well as a training process for new families coming into the foster parents program.
3. Foster and group home placement services.
4. Counseling services to child, natural and foster families during the individual child's placement.
5. Counseling and supportive services to restore family unity.
6. Reuniting families.
7. Counseling to secure future job training and employment.
8. Counseling for adoptive placement.

6. Health Related Services for Adults Program

Description: This program provides services to assist persons over age 18 to attain and retain an optimum condition of health by assisting in the utilization of necessary medical treatment services. Services of this program include helping people to understand their illnesses, arranging for transportation to and from medical services, working with individuals and family members to assure that medical recommendations are followed, and working with medical practitioners to assure that appropriate services are provided.

7. Health Related Services for Children Program

Description: Health related services for children are those services for children under age 18 that are related to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program is a medical service program for children of AFDC families that is funded through Title XIX. The health related services include informing parents of the program, assisting parents to carry out recommended medical findings through counseling, providing child care and arranging transportation for the initial examination and subsequent follow-up visits.

8. Homemaker Services Program

Description: Homemaker services include assistance and demonstration in meal planning, preparation and food buying, assistance with doctor and dental appointments, shopping for household items and clothing, clothing repair, light household chores and child management.

9. Information, Referral, and Follow-Up Program

Description: This service provides information to any person on request regarding Title XX and related programs. Where appropriate, referrals are provided to Title XX and other program resources, and follow-up is provided to assure the provision of services requested.

10. Institutional Placement and Counseling Program

Description: This program arranges appropriate institutional placement for individuals to nursing homes, boarding homes and personal care homes. Activities include pre-admission screening, monitoring and counseling after placement. In addition to the placement function, this program develops community placement and community care alternatives for persons presently residing in nursing homes. All eligible medical components will be paid for with Title XIX funds.

11. Legal Services Program

Description: Legal Services include legal counseling, advice, representation and appeal in civil matters, exclusive of criminal, fee generating, probate, and bankruptcy cases.

12. Protective Services for Adults Program

Description: Protective Services are services directed at the goal of preventing or remedying neglect, abuse, or exploitation of adults over age 18 who are unable to protect their own interest. Activities of this service include identification, investigation and diagnosis, provision of counseling, arrangement of appropriate alternative living arrangements, assistance in locating medical and legal care, including guardianship of person, arrangement of protective placement, and the provision of advocacy.

13. Protective Services for Children Program

Description: This program provides services to those under 18 years of age who are harmed or threatened with harm through nonaccidental physical or mental injury, sexual abuse, or negligent treatment or maltreatment. Activities of this program include identification and diagnosis, investigation, determination that individual is vulnerable or at risk of neglect, abuse or exploitation, counseling and therapy for parental figures and children, securing custody, identifying need for foster care or adoption, arranging for the provision of services outside the child's own home, and training parents or obtaining training courses for parents.

14. Services to Unmarried Parents Program

Description: This program provides counseling to one or both parents as a protective service which may include assistance for the following: placement in prenatal facilities, locating medical services, follow-up services to parent(s) after birth of child, follow-up on adoptive placements or assisting in the development of other needed resources.

Proposed Total Budget, FY 1979:

State Funds	Federal Funds	Local Funds
$1,302,078	$6,180,735	$1,009,422

Staffing: Total 391.81 FTE's

Evaluation:

At the present time, the Department of Social and Rehabilitation Services has two computerized data systems which are used by program staff to monitor and evaluate Title XX programs; these are the Montana Service System (MSS) and the Microdata Sampling System (MDSS). The MSS system is a reporting system that keeps records and information on all Title XX clients and is used for monitoring purposes. The MDSS system is the evaluation component to the MSS system. The MDSS system samples individuals on the MSS system and evaluates their progress through the social services system; this process is known as the "walk through". The "walk through" charts the progress of the client throughout the social service system. That is, clients are tracked through one or more of the five national Title XX goals in order to determine progress in achieving the goals. The Title XX goals are related to the achievement of obtaining self-sufficiency, self-supportiveness, appropriate institutional or deinstitutional placement, and protection from abuse. The MDSS system is used to show whether the Title XX service is having an effect, either beneficial or detrimental, upon the client. In this way, the MDSS system is used to indicate the quality of the services by guaging the service's influence upon the clients.

In addition to using the MSS and MDSS systems for the purposes of the evaluation, Title XX program managers evaluate each of their programs prior to the beginning of each fiscal year or contracting period. At this time the program manager determines whether or not a sufficient number of clients are being served, whether funds are being spent properly and effectively given the client load, the quality of the staff, and the quality of the service delivered.

DEVELOPMENTAL DISABILITIES DIVISION

Statutory Authority: Title 71, Chapters 2402, 2403, 2404 and 2414 R.C.M. 1947

Description: The Developmental Disabilities Division is responsible for the overall administration and coordination of two bureaus: Habilitation and Evaluation and Management and Planning. A primary focus by the Division is to provide statewide programs for the high risk population afflicted by mental retardation, cerebral palsy, epilepsy, autism, or any other neurological handicapping condition closely related to mental retardation. Many clients enrolled in community programs have been transferred to a community facility from Boulder River School and Hospital. Establishment of community facilities have provided some combination of living arrangements, livelihood, and continuing care or support to the clients. All programs take into account the fact that each individual has the right to autonomy and self-determination insofar as he/she has the capacity to exercise them.

Program Mission: As stated in the Executive Planning Process report, the Program Mission of the Developmental Disabilities Division is "To initiate a preventive developmental disabilities program which shall include, but not be limited to, the implementation of developmental disabilities care, treatment, prevention, and research as can best be accomplished by community centered services."

Goals and Objectives: Goals and Objectives provided by the Division in its Executive Planning Process report are as follows:

a. To continue the deinstitutionalization program of services to Developmentally Disabled persons and their families; including prevention of inappropriate institutional placement, through provision of a continium appropriate community-based service. (Community-Based Care & Treatment)

   (1) To provide services to 1251-1320 developmentally disabled adults including the following: Residential Services 468-472, Transportation Services 886-897, Vocational Services 856-865, Treatment and Follow-Along 25-30 and Evaluation and Diagnosis 20-25.
   (2) To provide services to 250-264 children and their families including the following: Residential Services, Family Training, Pre-School or Day Care, Treatment and Follow-Along, and Evaluation and Diagnosis.
   (3) To continue through the remainder of the present biennium and through the 1980-81 biennium providing the previously mentioned community services as program vacancies occur to DD individuals inappropriately served in institutions, long term care facilities, and existing community services.

(4) Provide at least five training sessions in each region to the significant others in the lives of the developmentally disabled, i.e., parents, family members, and consumers, that gives them an overview of the roles and responsibilities of the various agencies that comprise the DD Service Network and the laws and rights of the developmentally disabled clients and their parents. This will enable the client and/or parent to function efficiently and more independently in assessing the programs of the services network.

b. During the remainder of the 1978-79 biennium and through the 1980-81 biennium insure the programatic integrity and the highest degree of quality in all services provided the Developmentally Disabled in Montana. (Community-Based Care & Treatment)

(1) To provide training to 600 Title XX direct service staff to enable them to apply these skills and their knowledge in increasing the independent functioning level of persons with developmental disabilities by their active participation in the planning and implementation of Individual Habilitation Plans (IHP), design and implementation of Individual Program Plans (IPP) and documentation of client progress for each IPP.
(2) Provide, as requested, training to the 43 staff members of the DDD in IHP and IPP preparation and in other job related areas.
(3) On a request basis, provide training to 400 Title XX non-profit board members and regional council members in the following DD program areas: standards and regulations, contracting procedures, and legal and ethical responsibilities.

c. To develop additional community services for presently inappropriately served in nursing homes and institutions and unserved Developmentally Disabled persons. (Community-Based Care & Treatment)

(1) To increase the number of services, in the 1980-81 biennium, to provide 225 developmentally disabled persons including residential service alternatives, pre-vocational/vocational services, transportation services, respite services, follow-along and support, evaluation and diagnosis for adults in long term care facilities and institutions.
(2) To provide, during the 1980-81 biennium, the full continium of services for 82 adult developmentally disabled persons who are presently on waiting lists for entrance into community service programs.

d. During the 1980-81 biennium, design, develop, and initiate specialized community services for the most severly handicapped, developmentally disabled, including those with special medical needs, the profound and severly retarded, and those with multiple handicapping conditions. (Community-Based Care & Treatment)

(1) To conduct in cooperation with the Department of Health and Environmental Sciences and the Office of Superintendent of Public Instruction at least two (2) prevention workshops in each of the five administrative regions, serving a total of 250 people.
(2) To provide information through educational instruction and written materials that describes the causes of and suggests means to prevent developmental disabilities, for the distribution throughout Montana.
(3) To produce or gain access to media productions for public service advertising by television, radio, and newspapers, urging Montanans to avail themselves of appropriate pre-natal medical services.

The following narrative will give a brief description of Developmental Disabilities Division programs, budget, and staffing patterns. Purchase-of-Service Contracts have been established with 137 private providers for service/program delivery, while approximately 64 providers have been granted multi-contracts. These providers are in addition to state employees of the Division.

Habilitation and Evaluation Bureau

Residential Services

Description: Residential Services provides three types of living arrangments: Semi-Independent living, Foster home, and Community home. Semi-Independent living is a variably supervised situation oriented toward independent living; Foster home is a living arrangement with a family other than the natural family; and, a Community home is a supervised living situation which provides board and room in addition to focusing on developmental skills to prepare the DD for more independent living. Daily living training comprised of instruction in person care, self-help, and general skills needed for living in a community is supplied to the residents. The program is funded by Title XX and State funds.

Transportation Services

Description: Transportation Services enables clients to utilize generic and specialized services.

Vocational Services

Description: Vocational Services are a complex system of services directed toward productive work skills. Training ranges from pre-vocational skills, to specific vocational skills, to work activity, to sheltered employment, to employment by a vocational day activity, to contract work crews, to gain employment.

Treatment and Follow-Along Services

Description: Treatment and Follow-Along Services provide a continual point of contact for the client as to assure treatment plans are planned and implemented. Assistance may be provided in attaining services from other programs. i.e., schools, social services, mental health, etc.

Evaluation and Diagnostic Services

Description: Evaluation and Diagnostic Services provide clinical service to assess the level of development in terms of capability as well as deficiency. It generally involves a multi-disciplinary approach and in all instances provides detailed prescriptive reports.

Family Training and Resources

Description: Family Training and Resources are training services to assist family members in the training, care, and development of a child.

Pre-School or Day Care Services

Description: Pre-School or Day Care Services are center-based training services for children 0-5 years of age. Specialized training includes areas in speech, motor coordination, socialization skills, self-help skills, and some pre-school academics.

Management and Planning Bureau

Description: The Management and Planning Bureau provides the management information and comprehensive planning capability of the Division. In addition, this Bureau is responsible for providing consultation and guidance to the regional staffs and boards in terms of management and planning functions.

Management

Description: In addition to being the contact for Federal government and the Office of Budget and Program Planning, the major functions of the Management section are as follows:

1. Grants and contract management and monitoring.
2. Fiscal management, including liaison with SRS.
3. Budget development.
4. Conduct management studies.
5. Maintain a management information system.

Planning

Description: The major functions of the Planning section are as follows:

1. Prepare a State Plan with the State DD Council
2. Prepare DD portion of Title XX Plan.
3. Prepare DD portion of Health System Agency Plan.

Proposed Total Division Budget, FY 1979:

	State Funds	Federal Funds
Title XX	-0-	$3,192,262
Title XX (Training)	-0-	375,000
General Fund	$4,903,200	

($7,176,870 of the above funds are contract funds)

Staffing: 41 FTE's

Section VI

OVERVIEW OF EXISTING

FEDERAL AND STATE

PROGRAMS AND EXPENDITURES

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OVERVIEW OF EXISTING FEDERAL AND STATE PROGRAMS AND EXPENDITURES

The following section will report on existing Federal and State programs and expenditures. It will include private and public programs and expenditures--some of which will overlap the "State Agency Inventory" section.

NATIONAL EXPENDITURES FOR HEALTH

In fiscal year 1977, 162.6 billion dollars was spent on health care in the United States, which amounted to 8.8% of the Gross National Product (GNP). In 1970, 69.2 billion dollars was spent on health care in the U.S, or 7.2% of the GNP. Americans have been spending a greater proportion of their income on health care. In addition, the larger share of expenditures have been for hospital services. $65.627 billion (40.35%) was for hospital care in 1977 to 25.8 billion dollars (37.4%) of the GNP in 1970.

TABLE 1

NATIONAL HEALTH AND HOSPITAL EXPENDITURES
AND GROSS NATIONAL PRODUCT

UNITED STATES--FISCAL YEARS 1960-1976

Fiscal Year	Gross National Product (billions of dollars)	Total Health Expenditures (millions of dollars)	Health as Percent of GNP	Total Hospital Expenditures (millions of dollars)	Hospital as Percent of Health Expenditures
1959-60	$ 498.3	$ 25,856	5.2%	$ 8,499	32.9%
1964-65	658.0	38,892	5.9	13,152	33.8
1965-66	722.4	42,109	5.8	14,245	33.8
1966-67	773.5	47,879	6.2	16,921	35.3
1967-68	830.2	53,765	6.5	19,384	36.1
1968-69	904.2	60,617	6.7	22,356	36.9
1969-70	906.2	69,201	7.2	25,879	37.4
1970-71	1,019.8	77,162	7.6	29,133	37.8
1971-72	1,111.8	86,687	7.8	32,720	37.7
1972-73	1,238.6	95,383	7.7	36,155	37.9
1973-74	1,361.2	106,321	7.8	41,020	38.6
1975(1)	1,454.5	123,716	8.5	49,973	39.1
1976(1,2)	1,625.4	141,013	8.7	57,497	39.6
1977(2,3)	1,838.0	162,627	8.8	65,627	40.3

1 - Revised 2 - Federal Fiscal Year 3 - Preliminary Estimate

Source: Hospital Fact Book, California Hospital Association, 1977
National Health Expenditures, Health Care Financing Administration, 1977

The price of health care in the U.S. is a major concern. The concern with prices is not unique to the health field but characteristic of the entire economy. It is during tight economic times such as these that the interrelationship of various economic sectors of society become clearly evident- an increase or decrease in one section has an immediate and influential effect upon other sectors. This same principle applies within individual sections - such as health - as well as to the economy as a whole. Due to the limited scope of this report, however, the major concern will be with the cost of health care, not the economy as a whole.

The reasons for the increase in the price of health care are varied-- technological advances, inflation, insurance, malpractice, information gaps, lack of comparative shopping, excess beds, inappropriate use of services and regulations are just a few of the reasons for the increases.

For everyone's sake - especially the client and the health care provider - health care costs have to be held within affordable limits. If health care costs become unaffordable, both the quality and quantity of health care will be affected - health care providers will deliver fewer services because health costs will be out of the average person's reach and the health of people (quality) will decrease due to their inability to buy the necessary services. Such a prospect is deterimental to both the health care industry and the client.

Health care needs to be affordable by the largest number of people possible if it is to be effective. However, the present health economic system has been defined as a limited system - not all services can be delivered to everyone by all health care providers (P.L. 93-641). The three part division of health care into primary, secondary, and tertiary care is an excellent example of this "limited" definition. In other words, there needs to be a ratio between need and resources. That is, there should be only as many resources as there are needs. An excess of resources would increase the price of health care. Likewise, insufficient resources would reduce the availability of health care and the quality of health.

P.L. 93-641, the Health Planning and Resource Development Act of 1974 and P.L. 93-353, the Health Services Research, Health Statistics and Medical Libraries Act of 1974, provide the legal mandate for designing a rationalistic health delivery system. As a whole, both laws state that knowledge of health resources and health needs is necessary. In other words, a kind of accounting or balance sheet of resources and needs is called for. This report, then, is a preliminary attempt at creating this balance sheet. Specifically, the report will show health care expenditures (use of resources) for Montana. This balance sheet is not an answer to the problem of increasing health care expenditures but a method for defining the problem - one possible step toward assessment of the problem. The problem lies with the factors already mentioned - insurance, inflation, regulations and technology. See Table 2.

Distribution of Health Care Expenditures, United States and Montana by source of funds

TABLE 2	AGGREGATE AMOUNT (in millions)				PER CAPITA AMOUNT[a]		
	U.S.		MT.		U.S.	MT.	
TOTAL	148,571	% of Total	533.93	% of Total	673.3	701.62[e]	% of Total
Total Private	85,464	100.0	285.73	100.0	387.31	375.47	- 3.1
Direct Payment	43.274	50.6	149.24	52.2	196.11	196.11	N.A.
Health Care Contractors Commercial Ins.	39,299	46.0	126.54	44.3	178.10	166.28	- 6.6
Philanthropy & Industry[b]	2,891	3.4	9.95	3.5	13.08	13.08	- -
Total Public	63,107	100.0	248.20[d]	100.0	285.99	326.15	14.0
Medicaid	9,181	14.5	40.03	16.1	41.61	52.60	26.4
Medicare	20,770	32.9	60.13	24.2	94.12	79.02	16.0
Workers' Comp.[c]	2,125	3.4	8.10	3.3	9.73	10.65	9.5
State Hospitals	N.A.	- -	27.30	11.0	N.A.	35.88	N.A.
Federal Hospital	N.A.	- -	20.50	8.3	N.A.	26.99	N.A.
General Hospital & Medical	29,427	46.6	123.50	49.8	133.35	162.29	21.7
Other Public Health	3,729	5.9	11.20	4.5	16.89	14.72	12.8

a. 1976 U.S. Population=218,338,558; 1977 U.S. Population 220,660,787; 1977 Montana Population-761,000 (Bureau of Business & Economic Research)

b. There is no actual figure available for total source of funds from philanthropy and industry in Montana.

c. Workers' Comp. figures do not include expenses for administration. Sums may not total because of rounding.

d. Does not sum to total since some, but not all, duplicate funds (Medicare/Medicaid hospital payments) have been subtracted from the total hospital revenue figure of 123,501,825.

e. The Montana figure may be an over estimate due to some duplication in the figures for Montana. That is, some agencies were not able to break out costs for specific services but could only report a sum total figure. Those costs that could be broken out were but this does not eliminate 100% of the duplication. Hence, these total figures should be seen as estimates - but nevertheless, very useful estimates. Also, quite importantly, cost figures for individual programs like Medicare, Medicaid, etc, are actual expenditures and are accurate for the period and source reported.

EXPENDITURES FOR SPECIFIC SERVICES AND PROGRAMS RELATED TO HEALTH, MONTANA

Home Health

The Montana HSA defines home health services as: "home health care is the provision of health services and supportive services to patients in their own homes or at ambulatory settings for the purpose of preventing disease and promoting, maintaining or restoring health or minimizing the effects of illness or disability."

Home health is an alternative form of health care which can be a substitute for hospital, nursing home, or institutional care. Lacking the need for larger capitalization, home health care can be delivered more economically when compared to other institutionally based forms of service. Due to the extensive nature of need for services, both home health care and institutional care are needed. Each form of health delivery meets a specific need.

Home health in Montana is a new and developing form of service. Home health may only be at its initial capacity. The programs with the larger expenditures have been established longer and express a more mature ability to deliver home health services rather than indicate areas with greater need. See Table 3.

Community Mental Health

Mental illness is - "suffering from a mental disorder" or "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." (The Mental Health and Treatment Act of 1975, Section 38-1302, R.C.M. 1947).

Community mental health centers (see the map on the following page for Mental Health Regions) are mandated to deliver mental health services in a non-institutional setting. Their objective is to provide services to the emotionally disturbed. The primary treatment philosophy, in the past few years, has been centered upon deinstitutionalization - providing alternatives for institutionalization, "maintaining emotionally disturbed individuals in the least restrictive environment." See Tables 4 and 5.

MENTAL HEALTH REGIONS IN MONTANA

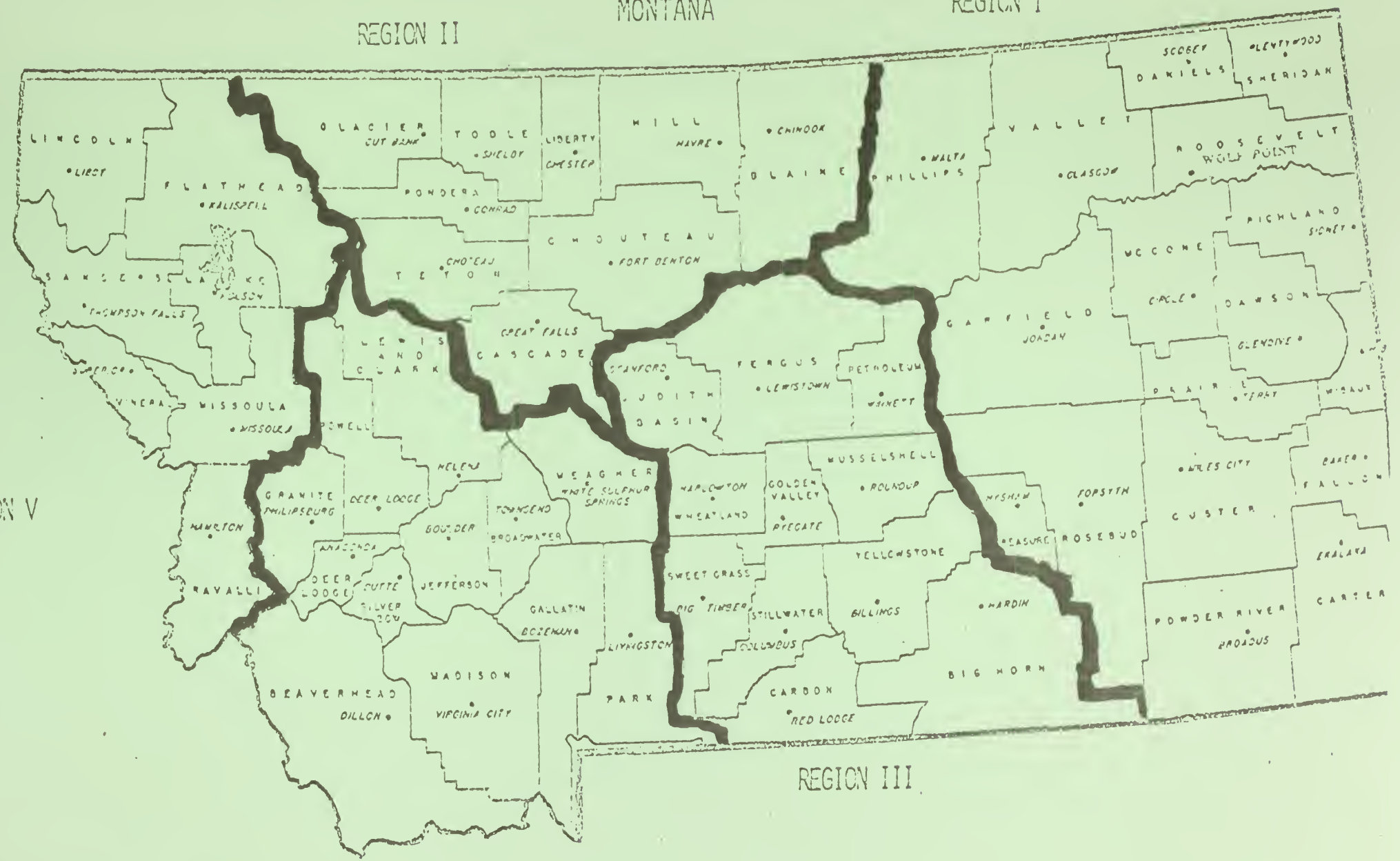

TABLE 3

HOME HEALTH EXPENDITURES, FY 1977

Missoula County Health	$463,368.00
Area V Anaconda	1,873.65
Deaconess (Great Falls)	56,923.00
West-Mont	357,975.06
Lake County Home Health	80,200.00
St. Joseph Hospital	8,434.00
Columbus (Great Falls)	28,172.00
Yellowstone	130,158.00
Butte	190,251.00
Holy Rosary	19,129.31
Sidney	96,017.00
Gallatin County	11,112.00
Ravalli	-0- **
Total:	1,443,613.02 ***

* Fiscal Year differs - some programs use the July - June fiscal years while others use the Oct. - Sept. fiscal year.
**Ravalli County Home Health Agency did not report.

Also, some of the programs only reported for part of the fiscal year since these are new programs. Fiscal years 1978 and 1979 may also show a substantial increase in Home Health services since new agencies are still coming into operation. At the time of this report there were sixteen (16) licensed Home Health Agencies and three (3) undergoing licensing, hence, six (6) Home Health Agencies are not reporting since these agencies did not exist in FY 1977.

***At the time of this report Flathead County Home Health had not sent in a report.

TABLE 4

Budget for the Community Mental Health Programs, FY 1977

Region I :	812,054	Region IV :	871,093
Region II :	1,337,853	Region V :	718,253
Region III :	1,068,179	Total :	4,807,432

The total per capita expenditures for mental health services in Montana is $6.32 per year.

TABLE 5

Comparison of Community Mental Health Funds and Population

	% Distribution of Community Mental Health Funds*	% of District of Population
Region I	16.9	12.8
Region II	27.8	19.8
Region III	22.2	19.8
Region IV	18.1	24.4
Region V	14.9	23.2
Total	100.0	100.0

*May not sum due to rounding.

ALCOHOLISM PREVENTION AND TREATMENT SERVICES

Montana law defines an alcoholic as: ...a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social and economic function is substantially disrupted (Section 80-2709, R.C.M. 1947)

The alcoholism programs are concerned with both treatment of the problem and also prevention.

Budget, FY 1977

Federal monies	$200,000
State monies:	
State public	$2,217,549
Local public	1,390,000
Total	$3,807,549

Per capita expenditure: $5.00 per year.

Federal funds are used for a number of preventative and service programs as follows:

1) Regionalization: Implementation of Regional Plans: $110,000
2) Fund Urban Indian Alcohol Programs: $30,000
3) Task Force and Research on Women's needs: $10,000
4) Youth Issue Task Force: $7,500
5) Development and implementation of Alcoholism Prevention, Education System: $22,500
6) Alcohol and Drug Abuse Division to Implement Alcohol MIS (Management Information System): $20,000

Total: $200,000

State Alcohol Tax Funding

1. Galen State Hospital/Alcohol Treatment and Rehabilitation: $1,000,000.
2. Alcohol and Drug Abuse Division: $200,000.
3. Eastern Montana Residential Treatment Program: $400,000.
4. Current level continuation of State approved alcohol programs (July - October 31, 1977): $400,000.
5. Support of State approved programs and finding new programs: $200,000.

Total $2,200,000

The remaining funds, $1,390,000, are derived from the alcohol tax and are distributed directly to counties. Each county decides its own use for this share of the alcohol tax money.

Drug Abuse Services

Montana law defines a drug abuser as: one who habitually lacks self-control as to the use of drugs, whether legal or illegal, or uses drugs to such an extent that his health is substantially endangered or his social or economic function is substantially disrupted. (80-2709, R.C.M. 1947)

To meet the drug abuse problem, Montana has three drug abuse and treatment programs:

The Southwestern Drug Program, Rimrock Drug Program (administered through a statewide service contract), and the Lighthouse Drug Program.

BUDGET

Southwestern	$468,733.00
Rimrock (Statewide Service Contract)	35,025.21
Lighthouse	118,128.69
Total	621,882.90
Per capita cost/year	82 cents

MEDICAID

The Medicaid program renders medical assistance to the needy through vendor payments. Payments are made for the care and treatment of illness, hospitalization, and rehabilitation of physical disabilities. The program is available to recipients of most public assistance programs, such as AFDC (Aid to Families with Dependent Children) and SSI (Supplemental Security Income) and others. Service is also provided to the medically needy whose income exceed AFDC guidelines on a fee-for-service basis.

Medicaid Expenditures FY's 1977 & 1978

Type of Service	Expenditures 1977	Expenditures 1978	Percent Difference
Inpatient	7,667,426	9,123,292	18.98
Outpatient	1,005,301	996,255	- .89
Physician	4,711,716	4,991,319	5.93
Other Prac.	990,180	1,099,069	10.99
Drugs	2,490,360	2,451,421	- 1.56
Dental	1,448,001	1,439,253	- .60
Skilled Nursing	7,601,072	3,808,713	- 49.89
Interm. Nursing	12,991,321	21,842,967	68.13
Laboratory	49,804	76,442	53.48
Home Health	151,931	189,229	24.54
Family Planning	218,534	191,084	- 12.56
Misc.	705,789	1,726,516	144.62
Total	40,031,435	47,935,560	19.74

Between 1977 and 1978

Medicaid expenditures have increased 19.74%. Skilled nursing has declined 49.89%; however, this decline is due largely to re-evaluation by PSRO of skilled nursing patients to intermediate nursing care. It is also important to note that Medicaid services (number of clients served, and services delivered) have not drastically increased nationally; the large increases have mainly been due to inflation and the rising cost of health care.

MEDICARE*

Expenditures for Medicare, FY 1977

BLUE CROSS

Hospital	$37,924,966.72	
Skilled Nursing	$860,735.54	
Physical Therapy	$40,465.26	
Home Health	$694,262.74	
	Sub Total	$39,520,430.26

BLUE SHIELD
(break-out of funds was not available) Sub Total $20,613,219

MUTUAL OF OMAHA		
Physical Therapy	$273,782.46	
Inpatient/Outpatient	$5,240.32	
Home Health	$80,219.16	
	Sub Total	$359,241.94

TRAVELERS INSURANCE

information not available

Total: $60,492,891.20
per capita expense: $79.49

*For a full explanation of the Medicare program see the appendix.

METHODOLOGY

Funds - United States and Montana

Direct Payment:

United States: Direct payment is the difference between total expenditures for health care services and the total payments made by all other sources1 .

Montana: Direct payment for Montana is estimated from the per capita figure of the U.S. as a whole. Direct payment information is not available for Montana specifically.

Health Care Contractors:

United States: Insurance figures from National Health Care Expenditures.

Montana: Insurance figures from the Secretary of State's Office. The figures represent CY 1977 premium income for Blue Cross, Blue Shield, and other hospital medical plans. These figures include administrative costs. Private companies include administrative costs for life insurance in their figures, however, it is not practically possible to separate the two administrative costs - for health insurance and life insurance.

Philanthropy and Industry:

United States: Figures from National Health Care Expenditures.

Montana: Estimates based on national per capita expense from National Health Care Expenditures.

Medicaid:

United States: Figures from National Health Care Expenditures.

Montana: Office of Budget and Program Planning.

Medicare:

United States: National Health Care Expenditures.

Montana: Blue Cross, Blue Shield.

Workers Compensation:

United States: National Health Care Expenditures.

Montana: Worker's Compensation Division, Helena, Montana.

State Hospitals:

United States: No data.

Montana: Department of Institutions.

Federal Hospitals:

United States: No data.

Montana: Montana Hospital Association.

General Hospital and Medical:

United States: National Health Care Expenditures.

Montana: Montana Hospital Association.

Other Public Health

United States: National Health Care Expenditures.
State/
Montana: Department of Health and Environmental Sciences.

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SECTION VII

STATE HEALTH POLICY ANALYSIS FRAMEWORK

OF THE

MONTANA

PRELIMINARY

STATE HEALTH PLAN

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VII. STATE HEALTH POLICY ANALYSIS FRAMEWORK

A. Introduction

Policy analysis of state health policy issues will be a major effort of the Montana SHPDA and SHCC in the upcoming years. Health policy analysis is a fairly new concept and has not been widely used; its exact nature may still be unclear to many people. Therefore, in this section of the Montana State Health Plan for 1979, we will define the nature of policy analysis (what it is) and how it can be important to health planning.

Explicitly, policy analysis is a tool for scientifically measuring the impact of existing and proposed policies governing a particular state health program or set of programs. Implicitly, it is a measurement of the effectiveness of state programs.

The overall purpose of state health policy analysis is to suggest and objectively analyze areas for policy or program development or change in order to contribute to informed decision-making.

Four types of policy analysis can be identified: initiatory, pre-decisional, review and evaluation.[1]

Initiatory and pre-decisional policy analysis occur before a policy is adopted and implemented. Initiatory policy analysis requires the analyst to formulate policy and actually propose it to the decision-maker. Pre-decisional analysis, on the other hand, is conducted at the request of the decision-maker who has a particular policy area in mind; the analyst's role is to determine the consequences of possible policy alternatives.

The other two types of policy analysis occur after a policy is implemented. Policy review is just what it says--a review or an inventory of existing policies. Policy evaluation goes one step further and measures the adequacy, effectiveness and efficiency of policies.

In health planning for State government, a need is evident for all four types of policy analysis.

The federal government recognized this need in its guidelines for State Health Plan development.[2] Those guidelines state that a SHPDA should conduct state health policy analysis, a process which would include:

1. an inventory of existing State and Federal health policies and programs;

2. a review of planned, proposed, or emergent policies and programs;

3. an articulation of goals and objectives reflected in the plans of other health and health-related programs;

4. an analysis of statewide forecasts of demand and need for health services and their supportive resources;

5. a cost impact analysis of current and proposed policies, health care financing methods, regulatory activities, and programs in the health field, on the performance of the health delivery system, and health status.

The guidelines state that, "Because of the large investment of State and Federal governments in health care in the States, and the need to review other State plans, it is essential that the SHPDA, in the conduct of its State policy analysis, incorporate an examination of State and Federally-sponsored programs operating in the State. This should include a review and analysis of population coverage, expenditures, utilization, goals and objectives of these State and Federal programs. The analysis should result, with increasing comprehensiveness in subsequent State Health Plans, in a measurement of the adequacy of both public and private policies and programs in the State and estimates of their effectiveness and efficiency in assuring the accessibility, acceptability, availability, continuity and quality of health services; restraining increases in the cost of care; and preventing unnecessary duplication of health services and resources."

Based on these guidelines and the evident needs of State government in Montana, this Montana State Health Plan for 1979 establishes a framework and base for future State health policy analyses.

It is the intent of the Montana SHPDA and SHCC that in the future such analyses will be conducted by them and by other health and health-related programs in Montana State government.

B. Policy Analysis Framework

The basic steps in a State health policy analysis are similar for all four types or stages of analysis, whether initiatory, pre-decisional, review or evaluation. Those steps are explained in the following pages.

1. Identification and Clarification of a Topic, Program, Problem or Policy Issue of Major Concern

Where a policy analysis begins depends on who initiates it, and on what kind of analysis is being conducted. In a policy review or policy evaluation, the area of concern may be a topic (such as health education), a program (such as family planning), a problem (such as a high incidence of unwanted teenage pregnancies), or a specific policy (such as a directive that sex education not be taught in public schools). Initiatory and pre-decisional analyses are more likely to begin with the examination of a specific problem or proposed policy.

In pre-decisional policy analysis, the policy-maker identifies the issue for analysis. In initiatory analysis, policy review, or policy evaluation, the issue is identified by the analyst, by a lead group such as the SHCC or SHPDA, or through an issue identification process involving a number of people or groups. Areas for initiatory analysis or policy evaluation may be indicated as a result of policy review.

Often clarification of the purpose and desired outcomes of the analysis is critical as well as clarification of the concern itself.

2. Establishment of Goals and Objectives Relative to the Concern

To perform a policy analysis of a particular concern, it is important to know why one is interested in considering policy development or changes. Generally, the reason is to bring about some changes in the effectiveness and efficiency of a health program or in the health status of a target population. By setting goals and objectives, the analyst describes how efficient and effective health programs should be and he establishes a measuring device for future evaluation of the policy analysis.

3. Exploration of the Area of Concern, Including its History, its Current Situation and Various Options for the Future

This is basically the data-gathering and research step of the analysis. The analyst needs to know:

a. the laws, regulations and policies related to the concern;

b. the programs and services directed at a concern, as well as their costs, utilization, location, target population, goals and objectives, etc.

c. the health status of the population affected by the concern;

d. the health needs of the population affected by the concern;

e. the problems related to the concern and the causes of those problems;

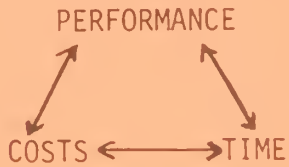
f. policy and program alternatives for addressing this concern.

Policy review stops with this step.

4. Measurement of the Consequences of Existing and Alternative Programs and Policies

In measuring the consequences of the outlined alternatives, it is helpful to look at the area of concern as a system. In such a way, the effects of each alternative on the system can be measured.

A system has three essential factors:[3] cost, performance and time. In a system with a shortage of resources, changes in one factor will always affect the others. In such a system, better performance requires either more time or cost, shorter time requires either more cost or lower performance, and lower cost requires more time or lower performance.



On the other hand, in a system with slack (excess resources), that slack can be applied to reduce cost, save time or improve performance.

If one thinks of this model in terms of building a house, the construction project can be completed faster with more workers or the house can be of a higher quality (e.g., plushier carpeting) if more money is spent. If the builder has more time, he can save money by employing fewer workers or he can build a higher quality house. If the builder sacrifices quality (e.g., no carpeting), he can save time or money.

In applying this systems model to measuring the consequences of proposed alternatives, the first step is to determine whether the area of concern has slack and how and if each alternative would use this slack. Indicators of slack are duplication or underutilization of programs and services and unused budgets. Cost effectiveness analyses can help determine areas of slack. A system with no slack and no shortage of resources has optimum use of resources. Although optimum use of resources is not always possible because demand is not always continuous, optimum use is a goal toward which programs and policies should be directed. Systems with resource shortages are faced with deciding the relative value of lower costs, less time and better performance (quality).

Another step in measuring the effect of existing and proposed programs is to estimate the costs (in terms of personnel, facilities, equipment, travel, etc.) and the time necessary to achieve objectives.

The next step is establishing performance standards or criteria. These criteria include accessibility, availability, quality, continuity and acceptability. Criteria may vary for each concern undergoing a policy analysis.

The final step is to describe the cost, time and performance effects of each outlined program or policy alternative. This description should include statements of how slack will be used to improve the program outcomes or the trade-offs involved in various proposals addressing a system with scarce resources.

5. Ranking Policy or Program Alternatives

After the consequences of each option have been described, the analyst should rank the options according to a set of established criteria. These criteria may include the performance criteria previously listed as well as criteria such as political feasibility and desirability, financial feasibility and ease of implementation.

6. Presentation of Policy and Program Options to Policy-makers

In the case of pre-decisional policy analysis, this step involves only clear, concise presentation of the analysis to the decision-maker who requested it. But for initiatory analysis, this step involves selling the policy options and the credibility of the analysis to decision-makers. This must be well thought out and planned long before a policy decision is due.

7. Evaluation of the Effectiveness of the Chosen Alternatives After They Have Been in Operation for a Period of Time

This step is important as verification of the policy decision. It involves going through the previous steps (with the exception of Numbers 1, 5 and 6) to determine whether the programs or policies are indeed contributing to the achievement of goals and objectives in the manner expected. If not, realignments may be required.

C. Present Mandates and Future Analyses

The SHCC identified lack of health education in the areas of prevention and proper utilization of health services as a top priority for policy analysis in the first Montana State Health Plan. That analysis, an initiatory analysis, will be included in Phase II of this Plan, which will be disseminated publicly in March, 1979.

The process for determining areas of concern for future policy analyses was described in the plan development process, Section I of this Plan.

FOOTNOTES

1 PACT Health Planning Center, State Health Policy Analysis, Denver, Colo., January 4, 1978.

2 Department of Health, Education and Welfare, Bureau of Health Planning and Resource Development, Guidelines for the Development of State Health Plans, August 18, 1978.

3 Weiss, Edmond, "Plan Development Series Session II, Priority Setting and Trade-off Analysis, "PACT Health Planning Center, Denver, Colo., October, 1977.

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APPENDICES

TO THE

MONTANA

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Appendix 1

EXECUTIVE SUMMARY OF THE MONTANA HEALTH SYSTEMS PLAN

When published in final form, this section will contain the Executive Summary of the 1979 Health Systems Plan. Since the HSP components are currently being revised, the Executive Summary cannot be presented at this time (it will be the last section of the Plan prepared).

The revised Plan is scheduled to be submitted for approval to the HSA Governing Board at its January meeting. After the Plan is approved, a copy of the Executive Summary will be sent to the SHPDA for its incorporation into this section of the State Health Plan. The format of the HSP's Executive Summary will be much the same as the current Plan's summary. The information presented will be similar but updated.

Appendix 2

Department of Health and Environmental Sciences
STATE OF MONTANA HELENA MONTANA 59601

A C Knight M D F C C P
Director

September 25, 1978

George Fenner, Administrator
Division of Hospital & Medical Facilities
Department of Health and
Environmental Sciences
Helena, Montana 59601

Dear George:

I am very much in agreement with the proposed role of the Bureau of Health Planning and Resource Development as presented in the document entitled "The Role of the SHPDA" dated September 18, 1978. Please consider this letter your authority to proceed with the implementation of the revised SHPDA role.

I realize that it will take several years to fully implement the role and that there are currently several pilot projects underway for this purpose. I will be following your progress with interest and expect to be periodically updated on the effort.

Integrated planning, service delivery and evaluation are certainly worthwhile goals to achieve. Please call upon my office when the need arises for any reasonable support you require for carrying out your role.

Sincerely,

A. C. Knight, M.D., F.C.C.P.
Director

EEO/AFFIRMATIVE ACTION AGENCY

THE ROLE OF THE SHPDA

September 18, 1978

The following paper presents the proposed role of the Bureau of Health Planning and Resource Development (SHPDA). The primary function of the Bureau will be one of program management through the coordination of health related services as a mechanism for ensuring quality health services for all the citizens of Montana.

PROGRAM MANAGEMENT CONCEPTS

Program management units should be independent without line authority over any service provider organizational elements. The program management unit influences the program's directions through leadership management techniques. When the unit encounters a problem that it cannot resolve through leadership techniques, it may call this problem to the attention of the appropriate level of line government with recommendations for resolution. This is possible and permissible because the unit is responsible for working at all levels of government to achieve program objectives. The benefits of improved effectiveness and efficiency are achieveable if the program management unit is not permitted to become entangled in the day-to-day responsibilities of line management duties. In other words, it should never be directly in charge of service provisions.

A well conceived and executed program management unit, therefore, functions by;

1. Utilizing leverage and influence rather than creating dependence upon the program's financial or service providing resources.

2. Being catalytic to the service providing agencies rather than in a line/directive relationship.

3. Coordination can be achieved through focusing on needs assessment, development of impact objectives, and information collection and dissemination particularly in the areas of impact, performance, and administrative evaluation.

4. Accepting product management responsibility despite its lack of authority.

5. Determining the degree to which the service delivery agencies' processes are contributing to the program's product objectives.

6. Establishing its right to existence from the viewpoint of the consumer who uses and/or pays for the end product.

SHPDA FUNCTIONS AND ROLE

The SHPDA is concerned with the health care services provided to all the citizens of Montana, and therefore will work to achieve the following objectives:

- to develop a coordinated and comprehensive approach to health problems within the state;

- to develop and articulate state health and health related policies;

- to guide resource allocation in the achievement of equal access to quality health care.

In order to achieve these objectives, the SHPDA proposes to function as a program management unit, concerned with inter-program management. The SHPDA has divided its responsibilities into five function areas as follows: (1) Health (Product) Planning; (2) Health (Product) Information and Data Systems; (3) Health Resource Coordination and Development; (4) Health (Product) Evaluation; and (5) Health Consumer Relations (Consumer advocacy, Ombudsman). The description of each functional area is presented below and is shown schematically on the attached chart (Health Program Coordination: Planning and Evaluation).

Health Product Planning

Program planning develops a product outcome strategy through the analysis of four primary inputs: consumer information, service provider information, statistical data, and methods research. Outputs of this strategy would include, for example, criteria and standards for health care services, or proposals for optimum utilization of health care resources.

Health Product Information and Data Systems

The information and data systems function includes collecting and analyzing information that is pertinent to the formulation and execution of both the total program and sub-program elements. It is concerned with data that can be used for targeting resources on the product so that the greatest return on available resources may be developed. This unit also assists in the verification of service provider performance and resource data.

Health Resources Coordination and Development

The resources coordination and development function includes responsibility for field coordination and liaison with all federal, state, county and local governmental entities which perform tasks within the health programs. In this capacity, the SHPDA coordinates, leads, and expedites the implementation of the management strategies that have been established and proven effective in these program areas. One vital function is to disseminate information that is developed through the program needs assessment, planning, and evaluation processes (e.g., use of evaluation data in the certificate of need process). Resources coordination and development, within the program management concept, also includes monitoring the implementation of planning strategies and facilitating inter and intra-agency performance.

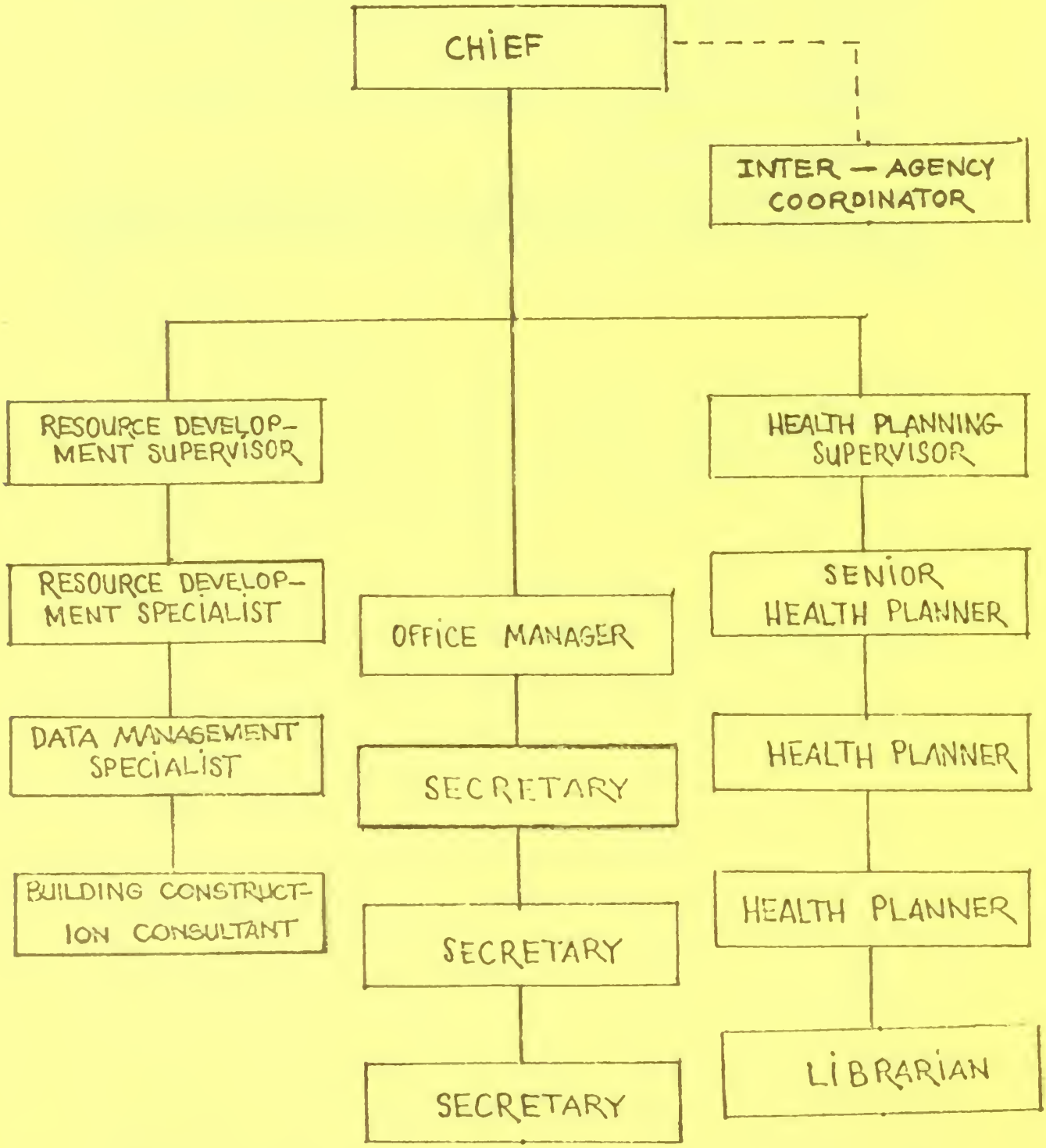
Health Evaluation

The management evaluation function is concerned with generating dynamic evaluation information that identifies the impact, performance and administrative progress of the programs. Evaluation is most critical to the effectiveness of the program management unit. Evaluation is the key feedback link for modification of objectives, functions, administrative practices and organizational structure. In order to perform its evaluation function, the SHPDA crosses existing organizational lines to look at elements of the program relative to achievement of program and sub-program objectives.

Health Consumer Relations

Consumer relations involves the dissemination of public information, coordination of public referral agencies, and assessment of consumer need.

Health Planning and Resource Development Bureau



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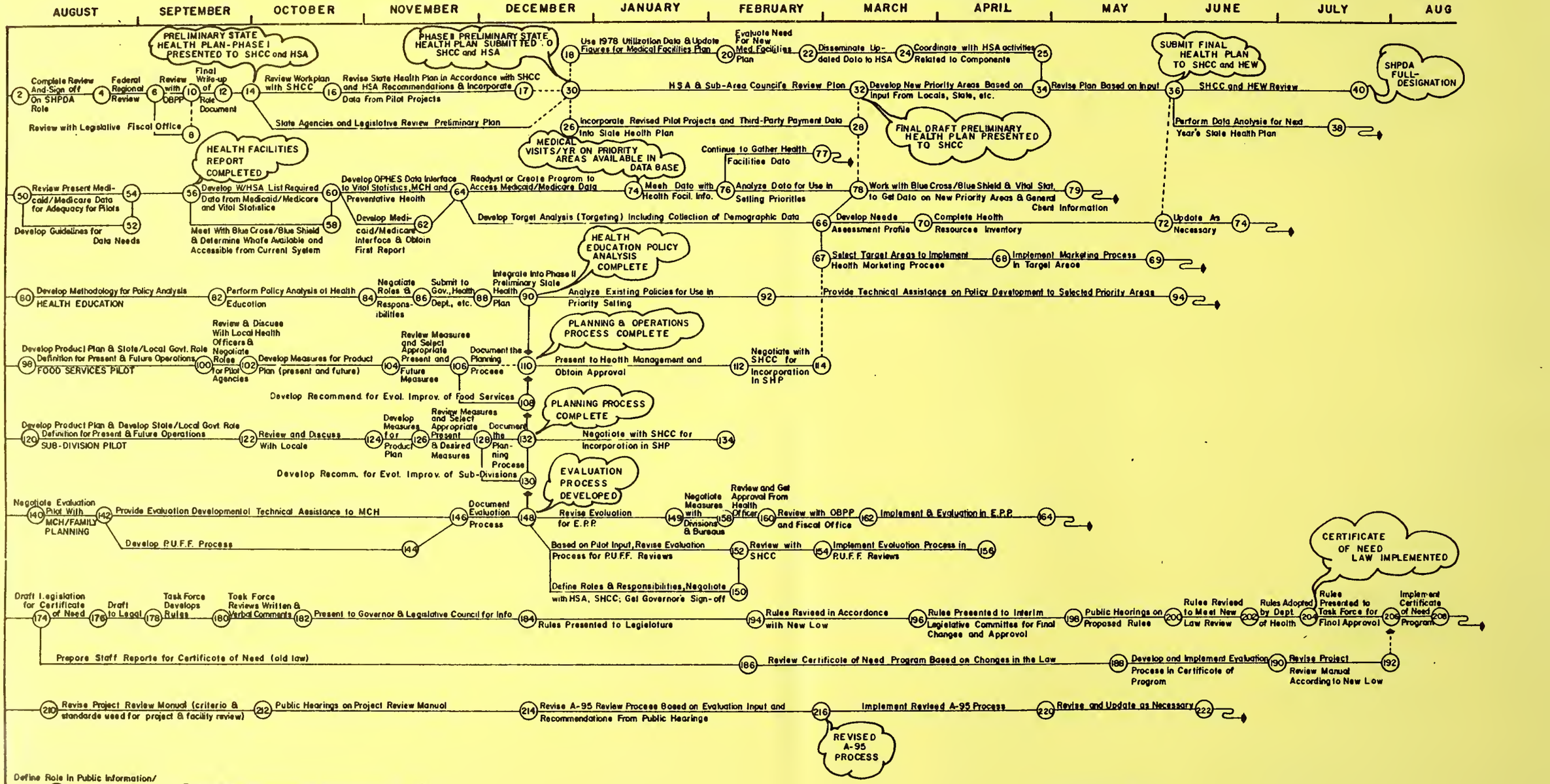
INTEGRATED HEALTH PLANNING & LOCAL EVALUATION WORK PLAN


AUGUST
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OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
APRIL
MAY
JUNE
JULY
AUG
PRELIMINARY STATE HEALTH PLAN-PHASE I PRESENTED TO SHCC and HSA
PHASE II PRELIMINARY STATE HEALTH PLAN SUBMITTED TO SHCC and HSA
SUBMIT FINAL HEALTH PLAN TO SHCC and HEW
SHPDA FULL-DESIGNATION
Complete Review And Sign off On SHPDA Role
Federal Regional Review
Review with OBPP
Final Write-up of Role Document
Review Workplan with SHCC
Revise State Health Plan in Accordance with SHCC and HSA Recommendations & Incorporate Data From Pilot Projects
Use 1978 Utilization Data & Update Figures for Medical Facilities Plan
Evaluate Need For New Med. Facilities Plan
Disseminate Updated Data to HSA
Coordinate with HSA activities Related to Componente
HSA & Sub-Area Council's Review Plan
Develop New Priority Areas Based on Input From Locals, State, etc.
Revise Plan Based on Input
SHCC and HEW Review
State Agencies and Legislative Review Preliminary Plan
Review with Legislative Fiscal Office
Incorporate Revised Pilot Projects and Third-Party Payment Data Into State Health Plan
FINAL DRAFT PRELIMINARY HEALTH PLAN PRESENTED TO SHCC
Perform Data Analysis for Next Year's State Health Plan
HEALTH FACILITIES REPORT COMPLETED
MEDICAL VISITS/YR ON PRIORITY AREAS AVAILABLE IN DATA BASE
Continue to Gather Health Facilities Data
Review Present Medicaid/Medicare Data for Adequacy for Pilots
Develop W/HSA List Required Data from Medicaid/Medicare and Vital Statistics
Develop OPHES Data Interface to Vital Statistics, MCH and Preventative Health
Readjust or Create Program to Access Medicaid/Medicare Data
Meet Data with Health Facil. Info.
Analyze Data for Use in Setting Priorities
Work with Blue Cross/Blue Shield & Vital Stat. to Get Data on New Priority Areas & General Client Information
Develop Guidelines for Data Needs
Meet With Blue Cross/Blue Shield & Determine What's Available and Accessible from Current System
Develop Medicaid/Medicare Interface & Obtain First Report
Develop Target Analysis (Targeting) Including Collection of Demographic Data
Develop Needs Assessment Profile
Complete Health Resources Inventory
Update As Necessary
HEALTH EDUCATION POLICY ANALYSIS COMPLETE
Select Target Areas to Implement Health Marketing Process
Implement Marketing Process in Target Areas
Develop Methodology for Policy Analysis HEALTH EDUCATION
Perform Policy Analysis of Health Education
Negotiate Roles & Responsibilities
Submit to Gov., Health Dept., etc.
Integrate Into Phase II Preliminary State Health Plan
Analyze Existing Policies for Use in Priority Setting
Provide Technical Assistance on Policy Development to Selected Priority Areas
Review & Discuss With Local Health Officers & Negotiate Roles for Pilot Agencies
Develop Product Plan & State/Local Govt. Role Definition for Present & Future Operations FOOD SERVICES PILOT
Develop Measures for Product Plan (present and future)
Review Measures and Select Appropriate Present and Future Measures
Document the Planning Process
PLANNING & OPERATIONS PROCESS COMPLETE
Present to Health Management and Obtain Approval
Negotiate with SHCC for Incorporation in SHP
Develop Recommend. for Evol. Improv. of Food Services
Develop Product Plan & Develop State/Local Govt. Role Definition for Present & Future Operations SUB-DIVISION PILOT
Review and Discuss With Locale
Develop Measures for Product Plan
Review Measures and Select Appropriate Present & Desired Measures
Document the Planning Process
PLANNING PROCESS COMPLETE
Negotiate with SHCC for Incorporation in SHP
Develop Recomm. for Evol. Improv. of Sub-Divisions
Negotiate Evaluation Pilot With MCH/FAMILY PLANNING
Provide Evaluation Developmental Technical Assistance to MCH
Develop P.U.F.F. Process
Document Evaluation Process
EVALUATION PROCESS DEVELOPED
Revise Evaluation for E.P.P.
Negotiate Measures with Divisions & Bureaus
Review and Get Approval From Health Officer
Review with OBPP and Fiscal Office
Implement & Evaluation in E.P.P.
Based on Pilot Input, Revise Evaluation Process for P.U.F.F. Reviews
Review with SHCC
Implement Evaluation Process in P.U.F.F. Reviews
Define Roles & Responsibilities, Negotiate with HSA, SHCC; Get Governor's Sign-off
CERTIFICATE OF NEED LAW IMPLEMENTED
Draft Legislation for Certificate of Need
Draft to Legal
Task Force Develops Rules
Task Force Reviews Written & Verbal Comments
Present to Governor & Legislative Council for Info
Rules Presented to Legislature
Rules Revised in Accordance with New Law
Rules Presented to Interim Legislative Committee for Final Changes and Approval
Public Hearings on Proposed Rules
Rules Revised to Meet New Law Review
Rules Adopted by Dept of Health
Rules Presented to Task Force for Final Approval
Implement Certificate of Need Program
Prepare Staff Reports for Certificate of Need (old law)
Review Certificate of Need Program Based on Changes in the Law
Develop and Implement Evaluation Process in Certificate of Program
Revise Project Review Manual According to New Law
Revise Project Review Manual (criteria & standards used for project & facility review)
Public Hearings on Project Review Manual
Revise A-95 Review Process Based on Evaluation Input and Recommendations From Public Hearings
Implement Revised A-95 Process
Revise and Update as Necessary
REVISED A-95 PROCESS
Define Role in Public Information/Consumer Relations
Provide Public Information & Referral Services
Negotiate with P.I. Office Inform HSA and SHCC
Develop Long Range Strategy on Collection & Use of Data for P.I.
Define Role Re: Consumer Advocacy
Inform HSA and SHCC
Implement Consumer Advocacy Role
Negotiate with Consumer Advocate in Governor's Office

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Appendix 3

HEALTH AND ENVIRONMENTAL SCIENCES, DEPARTMENT OF

DIRECTOR'S OFFICE

Room 200, Cogswell Building
Director, Arthur C. Knight, M.D. 449-2544

Information Unit
1400 11th Avenue, Hal Wheat Building
Information Officer, J. Anne Skinner 449-3763

CENTRAL SERVICES DIVISION

Room 234, Cogswell Building
Administrator, Robert A. James 449-2442

Planning and Evaluation Unit
Room 234, Cogswell Building
Chief, Robert L. Solomon 449-2442

Management Services Bureau
Room 234, Cogswell Building
Chief, Robert J. Redpath 449-2442

Records and Statistics Bureau
Board of Health Building
Chief, John C. Wilson 449-2614

Film Library
Librarian, Nancy Hampa 449-3444

ENVIRONMENTAL SCIENCES DIVISION

Board of Health Building
Administrator, Benjamin F. Wake 449-3946

Air Quality Bureau
Room 224, Cogswell Building
Chief, Michael D. Roach 449-3454

Food and Consumer Safety Bureau
Board of Health Building
Chief, Vernon E. Sloulin 449-2408

Occupational Health Bureau
Room 224, Cogswell Building
Chief, Larry Lloyd 449-3454

Solid Waste Management Bureau
1400 Eleventh Ave., Hal Wheat Building
Chief, Duane Robertson 449-2821

Subdivision Bureau
Board of Health Building
Chief, Edward Casne 449-3946

Water Quality Bureau
555 Fuller
Chief, Donald G. Willems 449-2406

HEALTH SERVICES DIVISION

25 South Ewing, St. John's Hospital Building
Administrator, John S. Anderson, M.D. 449-2554

Dental Health Bureau
1400 Eleventh Ave., Hal Wheat Building
Chief, Arthur J. Terrill, D.D.S. 449-3429

Maternal and Child Health Services Bureau
25 South Ewing, St. John's Hospital Building
Chief, Hendrika VanDrunen 449-2554

Nursing Bureau
25 South Ewing, St. John's Hospital Building
Chief, Althea Ginnebaugh 449-2076

Preventive Health Services Bureau
25 South Rodney
Chief, Martin D. Skinner, M.D. 449-2645

HOSPITAL AND MEDICAL FACILITIES DIVISION

836 Front Street
Administrator, George M. Fenner 449-2037

Emergency Medical Services Bureau
Chief, Drew Dawson 449-3895

Facilities Licensing and Certification Bureau
Chief, Jacquelin McKnight 449-2037

Health Planning & Resource Development Bureau
Chief, Wallace A. King 449-3121

LABORATORY DIVISION

Chemistry Laboratory Bureau
Room 231, Cogswell Building
Chief, Walter Jankowski 449-3644

Microbiology Laboratory Bureau
Room 139, Cogswell Building
Chief, Michael Skeels 449-2642

LEGAL DIVISION

1400 Eleventh Ave., Hal Wheat Building
Administrator, Sandra Muckleston — 449-2630

INSTITUTIONS, DEPARTMENT OF

DIRECTOR'S OFFICE

1539 Eleventh Avenue
Director, Lawrence M. Zanto — 449-3930

ALCOHOL AND DRUG ABUSE DIVISION

1539 Eleventh Avenue
Administrator, Michael A. Murray — 449-2827

MENTAL HEALTH AND RESIDENTIAL SERVICES DIVISION

1539 Eleventh Avenue
Administrator, Laurance B. Carlson — 449-3964

LABOR AND INDUSTRY, DEPARTMENT OF

COMMISSIONER'S OFFICE

Room 412, Employment Security Building
Lockey and Roberts
Commissioner, David E. Fuller — 449-2621

Safety and Health Bureau
510 Logan Street
Chief, Max Salazar — 449-3402

PUBLIC INSTRUCTION, OFFICE OF THE SUPERINTENDENT OF

SUPERINTENDENT'S OFFICE

Room 106, State Capitol
Superintendent, Geogria Ruth Rice — 449-3654

BASIC INSTRUCTIONAL SERVICES

1300 Eleventh Avenue
Co-Director, Lyle Eggum — 449-2418

SOCIAL AND REHABILITATION SERVICES, DEPARTMENT OF

DIRECTOR'S OFFICE

Room 301, SRS Building
111 Sanders
Director, Keith Colbo — 449-5622

COMMUNITY SERVICES DIVISION

Room 205, SRS Building
111 Sanders
Administrator, Edward J. Malensek 449-3467

Aging Services Bureau
Chief, 449-3124

Child & Youth Development Bureau
Chief, Charles McCarthy 449-3724

Social Services Bureau
Chief, Norma Cutone 449-3729

DEVELOPMENTAL DISABILITIES DIVISION

Room 305, SRS Building
111 Sanders
Administrator, 449-2995

Appendix 4

PROVISIONS OF THE LAW AND REGULATIONS

THE MEDICARE program, enacted on July 30, 1965 as Title XVIII of the Social Security Act, became effective on July 1, 1966. In 1972 major changes were made in the program's provisions by Public Law 92-603 enacted October 30, 1972. The name of the Medicare program was officially changed to Health Insurance for the Aged and Disabled.[1]

Effective July 1, 1973, Medicare coverage was extended to disabled beneficiaries under the social security or railroad retirement programs, and to persons under age 65 who require dialysis or a kidney transplant for chronic renal disease.

The program makes available two separate but complementary insurance programs: hospital insurance, covering nearly all persons age 65 and over and disabled beneficiaries under age 65 entitled to benefits for at least 24 consecutive months, and covered workers and their dependents with chronic renal disease who require renal dialysis or a kidney transplant; and supplementary medical insurance, covering those persons who voluntarily pay the premiums. Beginning July 1973, most persons age 65 or over otherwise ineligible for hospital insurance may enroll voluntarily and pay the premiums for hospital coverage if they are enrolled for supplementary medical insurance.

HOSPITAL INSURANCE PROGRAM

The hospital insurance (HI) program pays for part of the cost of inpatient hospital care and related health care services provided by skilled nursing facilities (formerly termed extended-care facilities) and home health agencies following a period of hospitalization. For the services to be covered, they must be provided by institutions and organizations which have been certified as qualified providers of services and which have signed an agreement to participate in the program.[2] An exception exists under special provisions for hospitals certified to provide only emergency services.

Benefits

The law provides limits on services which may be covered under the HI program. These limits are based on the concept of a "benefit period." A benefit period begins with the first day of hospitalization and ends when the individual has not been a bed patient in a hospital or skilled nursing facility for 60 consecutive days.

The law also established cost sharing by the individual through deductible and coinsurance payments. The Secretary of Health, Education, and Welfare is required each year to determine the deductible amount, by a formula, specified by law, which is based on the average per diem rate for inpatient services furnished beneficiaries during the preceding calendar year. The deductible amount tends to approximate the current cost of 1 day in a hospital. The coinsurance amount for hospital inpatient care is set at one-fourth of the deductible, for lifetime reserve days at one half of the deductible, and for skilled nursing facility services at one-eighth of the deductible.

Inpatient hospital benefits.— Covered hospital services include room and board in accommodations containing from two to four beds, nursing services (except for private duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients.

The program does not cover the services of physicians (including staff radiologists, anesthesiologists, pathologists and psychiatrists) except for services provided by interns or residents under approved teaching programs.

The program pays for the "reasonable costs," of covered services in a participating hospital for up to 90 days in a benefit period. Full payment is made for the first 60 days of hospitalization, less a deductible applicable to each benefit period. The deductible, which is adjusted each year, was $104 in 1976 (the year of data in this report) and rose to $144 in 1978. For each of the remaining 30 days in the benefit period, the patient pays a coinsurance amount equal to one-fourth of the deductible.

Each hospital insurance beneficiary also has a "lifetime reserve" of 60 additional hospital days which can be used at his option whenever he has exhausted the 90 days covered in a benefit period. Lifetime reserve days were subject to a copayment of $52 per day equal to one-half of the deductible in 1976. In 1978, this increased to $72.

The cost of the first three pints of blood (or equivalent amounts of packed red blood cells) furnished a patient during a benefit period is also deductible unless the patient arranges for replacement. Charges for any additional blood are covered under the program as are charges for blood administration, storage, etc.

The program also pays for emergency services in a nonparticipating hospital. Each nonparticipating hospital providing emergency services may elect to claim payments from the Medicare program for emergency services rendered bene-

[1] For a description of the provisions of the Social Security Act as amended through January 4, 1975, see *The Social Security Act*, Committee on Finance, U.S. Senate, 94th Congress, 1st Session.

[2] For certification requirements see Social Security Administration, Office of Research and Statistics, *Medicare—Health Insurance for the Aged, 1972-74, Section 3 Participating Providers* (Washington, D.C.: U.S. Government Printing Office, 1976).

ficiaries in a given year. If the hospital elects this option, reimbursement is made as described above. If the hospital elects not to bill the program, the beneficiary claims direct payment and submits the itemized bill. In this case reimbursement is based on reasonable charges for covered services and amounts to 60 percent of reasonable charges for room and board plus 80 percent of such charges for ancillary services. Payment is subject to the deductible and coinsurance provisions of the law.

Hospital insurance benefits also include reimbursement for inpatient tuberculosis and psychiatric hospital services. However, there is a lifetime limit of 190 days of care in the psychiatric hospital. When a person in a participating psychiatric hospital becomes entitled to hospital insurance, the number of days he was such an inpatient in the 150-day period prior to his eligibility is deducted from his days of entitlement to inpatient psychiatric care in that benefit period, but not from the lifetime limitation.

Hospital insurance benefits have been extended to cover payments for inpatient services furnished by a foreign hospital, if it is closer to or more accessible to the beneficiary's residence than a U.S. hospital. For benefits to be payable the beneficiary must be a U.S. resident and the foreign hospital must be accredited by, or have standards equivalent to, the Joint Commission on Accreditation of Hospitals (JCAH).

Skilled nursing facility benefits.—Covered extended-care services furnished by a skilled nursing facility include nursing care; room and board; physical, occupational or speech therapy; drugs and biologicals; medical services of an intern or resident-in-training of a hospital having a transfer agreement with the skilled nursing facility; and other necessary health care services generally provided by such facilities.

The program pays for the reasonable costs of all covered inpatient services in participating skilled nursing facilities for up to 100 days in a benefit period. Benefits are payable only following discharge from a hospital after a stay of 3 consecutive days or more; generally the admission to the facility must occur within 14 days of hospital discharge. However, a period of up to 28 days after discharge from a hospital is permitted when the patient's medical condition or shortage of beds delay the admission date. Full payment is made for the first 20 days. For each of the remaining 80 days, the patient pays a coinsurance amount per day equal to one-eighth of the inpatient hospital deductible ($13 in 1976, and $18 in 1978).

For extended-care services to be covered, a physician must certify that the patient needs daily skilled nursing care or related rehabilitation services and must order the services. The 1972 amendments include a provision for advance approval of extended-care services, whereby the Secretary of HEW establishes, by medical condition, when a patient will require skilled nursing care services after hospitalization. Accordingly, a patient's physician may certify the need for a skilled nursing facility and submit a plan, in advance of admission, as to the type of services to be provided. The skilled nursing facility.

Post-hospital home health benefits.—Covered home health services may include part-time or intermittent nursing care; physical, occupational or speech therapy; part-time or intermittent services of a home health aide; medical supplies (other than drugs and biologicals) and the use of medical appliances; and, in certain cases, services of an intern or resident-in-training of a teaching hospital. The services must be furnished by or under arrangements of an approved home health agency.

Coverage under HI provides for payment of the reasonable cost of up to 100 home health visits after the beginning of one benefit period and before the beginning of the next. There is no deductible and no coinsurance. The visits must occur within a year following a beneficiary's most recent discharge from a hospital stay of at least 3 consecutive days or from a covered stay in a skilled nursing facility. The home health services must be necessary for further treatment of a condition for which the patient received services in the hospital or skilled nursing facility. A home health plan must be established by the patient's physician within 14 days after the hospital or skilled nursing facility discharge. The 1972 amendments include a provision for advance approval of home health coverage similar to that provided for skilled nursing care services.

SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The supplementary medical insurance (SMI) program provides coverage for a variety of medical services and supplies furnished by physicians or others in connection with physicians' services; outpatient hospital services, and home health services. Individuals participate voluntarily in the program. Premiums are paid by or on behalf of all enrollees, and by the Federal Government from general revenues.

Benefits

Physicians' services covered under the program include visits to the home, office, hospital, and other institutions. The program also pays for other services and supplies, such as drugs and biologicals that cannot be self-administered, if they are furnished as a part of a physician's professional service; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests, X-rays, radium, and radioactive isotope therapy; splints, casts, and other devices used for reduction of fractures and dislocations; purchase or rental of durable medical equipment; ambulance service; and prosthetic devices that replace all or part of an internal organ. Also provided are home health visits provided by a certified home health agency in accordance with a home health plan established by the patient's physician (no prior hospitalization is necessary). Payment may be made for up to 100 home health visits in a calendar year without regard to similar services received under the HI program.

Also covered are hospital services incident to physicians'

physical therapy services. In addition, effective July 1, 1973, the 1972 amendments provide for services of a physical therapist in independent practice furnished in his office or the patient's home, under a physician's plan. Reimbursement would be limited to not more than $100 of incurred expenses in a calendar year.

Some services of a licensed chiropractor are covered. Covered services are limited to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

In each calendar year through 1972, a $50 deductible had to be satisfied before payment could be made under the SMI program. In 1973, the deductible was raised to $60, where it remains currently. Bills count toward the deductible on the basis of incurred rather than paid expenses; only charges allowed under the program count toward the deductible. To preclude the possibility of a beneficiary having to meet a deductible twice in a short period of time, a "carryover" provision is applied. Accordingly, covered expenses incurred in the last quarter of the year and applied to the deductible in that year are also credited toward the deductible for the following year.

After the deductible has been met, the SMI program pays for 80 percent of the allowed (reasonable) charges for covered physician services and most other medical services. However, deductible and coinsurance requirements do not apply to the services of radiologists and pathologists furnished to hospital inpatients. "Reasonable" charges for such services are reimbursed.

When an independent laboratory bills patients directly and accepts assignment, the Secretary is authorized to negotiate a payment rate with the laboratory for the diagnostic tests it provides Medicare beneficiaries. Reimbursement on assigned bills is made at 100 percent of the negotiated rate; the deductible and coinsurance requirements do not apply. Hospital services, incident to outpatient care, and home health services, are subject to the deductible and are reimbursed on the basis of 80 percent of reasonable costs. However, coinsurance payments for home health services were eliminated after December 1972.

The law sets special limits on the payment which may be made for outpatient treatment of mental illness; recognition of incurred expenses is limited to the lesser of $312.50 or 62.5 percent of actual expenses in a calendar year. Since only 80 percent of allowed charges may be reimbursed, the effect is to limit payment to $250 or 50 percent of the allowed charges in any year after the deductible has been met, whichever is less.

ELIGIBILITY

Hospital Insurance

Almost all persons aged 65 and over are eligible for benefits under the hospital insurance program. Included are those entitled to monthly social security cash benefits or payments from the railroad retirement system. Further, a special transitional provision provides eligibility for certain persons who do not qualify for monthly cash benefits on the basis of their own covered employment or as a dependent or survivor of an insured worker. The provision applies, generally, to a person aged 65 or over who (1) attained age 65 before 1968 or (2) attained age 65 after 1967 with not less than three quarters of social security coverage, whenever acquired, for each calendar year elapsing after 1966 and before the year in which he attains age 65. For persons who reach age 65 after 1968, the amount of work credits (quarters of coverage) needed increases by three quarters each year---six quarters are needed by those who reached age 65 in 1969, nine by those who reached 65 in 1970 and so on. The transitional provision does not apply to persons attaining age 65 after 1974.

Hospital insurance protection under certain circumstances can be retroactive for as many as 12 months before the month an individual files his application for entitlement. For example, an individual may apply 11 months after he attains age 65 and still be entitled to benefits from the month he attained age 65.

Effective July 1, 1973, disabled persons entitled for not less than 24 consecutive months to cash benefits under the social security or railroad retirement programs are eligible for benefits under the hospital insurance program. Those covered include disabled workers under 65 years, disabled widows and disabled dependent widowers between the ages of 50 and 65, women age 50 or older entitled to mother's benefits who for 24 months met requirements for disability benefits but did not file a claim, and disabled beneficiaries aged 18 or over who became disabled before age 22. A person must be disabled for 5 months before disability benefits can begin. Medicare coverage begins with the 30th month after the first full calendar month of disability.

Hospital insurance protection was also extended to persons under age 65 who are currently or fully insured or entitled to monthly social security benefits, and to their spouses or dependent children who have chronic renal disease and require renal dialysis or a kidney transplant. Eligibility for coverage begins with the 3rd month after a course in renal dialysis begins or before this qualifying dialysis period for CRD beneficiaries receiving kidney transplants without starting or receiving dialysis in preparation for transplantation. Eligibility ends with the 12th month after the person had a kidney transplant or dialysis was terminated.

The law now permits persons attaining age 65 who are ineligible for hospital insurance either as cash beneficiaries or under the transitional provisions to purchase hospital coverage.

Coverage under this provision was effective July 1, 1973, and the monthly premium set at $33 rose to $36 starting July 1, 1974, to $40 beginning July 1, 1975, to $45 on July 1, 1976, and will be $63 on July 1, 1978. The premium

represents the estimated per capita cost for services furnished under the hospital insurance program. Individuals may enroll in the hospital insurance program only if they enroll in the supplementary medical insurance program. Enrollment periods for hospital protection were the same as the initial and general enrollment periods under supplementary medical insurance.

Persons who retired from Federal service after July 1, 1960, and had the opportunity to be covered under the Federal Employees Health Benefits Act of 1959 are ineligible for hospital insurance benefits under the transitional provisions.

Also ineligible are aliens with less than 5 years of continuous residence in the United States, and those persons convicted of crimes against the security of the United States.

Supplementary Medical Insurance

Persons entitled to benefits under the hospital insurance program, retired Federal employees, aliens residing in the United States, and persons not eligible for hospital insurance under the transitional provisions may participate voluntarily in the SMI program. To enroll prior to July 1, 1973, the person had to file a written request with the Social Security Administration during specified periods. To prevent loss of entitlement or delay, the 1972 amendments provide for automatic enrollment in SMI for persons as they become entitled to hospital insurance. An individual may decline SMI enrollment. If he withdraws before his coverage starts, there is no premium liability, nor is he charged with an enrollment.

Individuals may enroll in the SMI program only during the initial and general enrollment periods. The initial enrollment period begins with the third month preceding the one in which an individual is first eligible and ends 3 months after the month of attainment, a total period of 7 months. If he enrolls during the 3 months prior to the month in which he is first eligible, his coverage is effective with the month in which he is first eligible; if he enrolls during the month he is first eligible, his coverage begins the following month, if he enrolls in any of the 3 months after he is first eligible, his coverage begins from 2 to 3 months after enrollment, depending on how long he waited before enrolling.

Beginning with 1969, SMI general enrollment periods are from January 1 through March 31 of each year for those who did not enroll in their initial enrollment period or who previously terminated their enrollment and wish to re-enroll. A person who enrolls during a general enrollment period is covered under SMI beginning with July 1 of the year in which he enrolls. Prior to the 1972 amendments, an eligible individual had to enroll within 3 years after the end of his initial enrollment period or within 3 years after termination of prior enrollment. The 3-year limitation is no longer applicable. Re-enrollment is allowed only once.

A State may enroll eligible aged and disabled individuals who receive cash payments under State supplementary income or State supplementation programs or are otherwise eligible for medical assistance under Title XIX if: (a) prior to January 1, 1970, the State requested that a State-Federal enrollment agreement be established, and (b) the State pays the necessary premiums.

For a person 65 years and over, enrollment terminates with the beginning of the month following the month of death. For the disabled person, coverage terminates with the end of entitlement to benefits based on disability. For a person with chronic renal disease, coverage ends 12 months after he had a transplant or dialysis treatment ends. Otherwise, social security and railroad retirement beneficiaries may give notice of their desire to withdraw from the SMI program at any time; their coverage is terminated at the close of the following calendar quarter. Other enrolled persons may terminate their coverage by withholding payment of premiums or by notifying the Social Security Administration in writing of their desire to withdraw from the program. The enrollee is provided a 90-day grace period for the payment of overdue premiums after which coverage is automatically terminated. The 1972 amendments extend the 90-day grace period for an additional 90 days when the Secretary finds there is a good cause for failure to pay the premium before the end of the initial 90-day grace period.

FINANCING THE PROGRAM

Hospital Insurance

The hospital insurance program is financed primarily through a tax on a portion of current earnings in employment covered under the Social Security Act. The maximum amount of annual earnings to which the tax is applied began at $6,600 for calendar year 1966; it increased to $7,800 effective with 1968 and $9,000 effective with 1972. The 1972 amendments established an automatic adjustment procedure for determining maximum annual earnings based on rising wages. The maximum earnings amount was $15,300 for 1976 and $16,500 for 1977.

The same tax rate applies to employees, employers, and self-employed persons. The rate was 0.60 percent for each year 1968–72. The scheduled rate for 1973 was 1.00 percent, 0.9 percent for 1974–77, and rates increase for future years up to 1.5 percent for 1986 and thereafter. The proceeds of this tax, and monies collected from the railroad retirement system (with respect to the coverage of railroad retirement beneficiaries) are placed in the Federal hospital insurance trust fund from which reimbursement for all benefits and administrative expenses incurred under the hospital insurance program is made. The hospital insurance trust fund is reimbursed from general tax revenues for the cost of providing coverage for the persons who qualify for hospital insurance under the transitional provisions. Amounts paid for hospital insurance coverage by persons voluntarily paying the premiums are deposited in the hospital insurance trust fund.

Supplementary Medical Insurance

Premiums are paid into the Federal supplementary medical insurance trust funds by those persons enrolled for sup-

plementary medical insurance (or on their behalf), and a matching amount is paid by the Federal Government from general revenues. Benefits and administrative costs are paid from monies in the SMI trust fund.

The premiums of persons receiving social security cash benefits, railroad retirement, or Federal civil service annuities are deducted from their monthly benefit checks. Persons not receiving monthly benefits are billed quarterly for premiums by the Health Care Financing Administration or the Railroad Retirement Board and have a 90-day grace period in which to make payment. A person is given an additional 90 days to pay the premium when the Secretary finds there is good cause for failure to pay the premium before the end of the initial 90-day grace period. Premiums may be paid for as long as a year in advance. For individuals financially unable to make quarterly payments, arrangements can be made for monthly payments.

Amount of premium.—The Secretary of HEW is directed by law to determine the SMI premium rate on an annual basis. The dollar amount, prior to the amendments of 1972, was required to be sufficient to produce revenue equal to one-half the expected benefit and administrative costs payable under SMI during the period in which the rate applied. Between 1966 and 1972, the premium increased from $3.00 to $5.80 a month. The 1972 amendments made changes in the method of premium determination. The rate is to be determined in December each year and is applicable for 12 months beginning the following July. It will be increased only in the event of a general cash benefit increase. The percentage increase in the premium in any given year may not exceed the percentage increase in cash benefits. Futher, the rate must be determined so that the revenue produced does not exceed, but may be less than, one-half the expected SMI costs. The monthly rate was $6.70 to July 1976 and increased to $7.20 effective July 1977. In July 1978 it will be $8.20.

ADMINISTRATION OF THE PROGRAM

Hospital Insurance

Under the HI program, groups or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency or organization to serve as an intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee if approved by the Secretary and agreeable to the intermediary selected. In addition, a provider may deal directly with the Health Care Financing Administration.

The Secretary may enter into an agreement with a nominated organization if he finds this to be consistent with effective and efficient administration of the hospital insurance program. Under the agreement, the intermediary determines the provider's reasonable costs for items and services covered under the program; makes payment; and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for (1) furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; (2) serving as a center for communicating with providers; and (3) making audits of provider records. Hospital insurance intermediaries also make payments for home health and outpatient hospital services covered under medical insurance.

Under the law, the reasonable costs of services are determined pursuant to regulations established by the Secretary of HEW. These regulations prescribe the method(s) used to determine costs and the items to be included; they take into account both direct and indirect patient care costs.[3]

Requests for Medicare payment for covered services generally are submitted by the provider of services; they must be signed by the beneficiary (or someone for him, if he is unable to do so). The provider is reimbursed on the basis of reasonable costs of covered services and bills the beneficiary for deductible and coinsurance amounts as well as for services not covered by the program.

In some instances, hospitals may bill the program on a physician's behalf for services rendered to inpatients. In these cases, payment is made by the HI intermediary. For this type of billing, funds are transferred from the SMI trust fund to the HI trust fund to cover the cost of these services.

The intermediary selected by the provider reviews claims for payment and pays the provider. Actual payment for individual claims is made on the basis of an interim rate established between the provider and the intermediary. Final settlement for each provider's operating year is made on the basis of a cost report submitted by the provider, and subject to an independent audit.

No payment can be made to Federal facilities except for emergency services, unless the provider serves as a community institution. In addition, payment cannot be made to a provider for those services it is obligated to render at public expense under Federal law or contract.

Supplementary Medical Insurance

Under the SMI program, the Secretary of HEW may enter into contracts with carriers for the performance of specified administrative functions. The carrier's principal function is to determine whether charges are allowable (reasonable) and to make payment. Carriers also have the authority and responsibility to determine, in a given case, whether a claim is for a covered service and to deny claims for noncovered or excluded items or services. In addition, carriers are to assist in applying safeguards against unnecessary use of services.

The allowable charge, on which the Medicare SMI payment is based, may not exceed the lowest of (1) the physician's or supplier's customary charge for the service, (2) the prevailing charge in the locality for similar services, or (3)

[3] For details see Code of Federal Regulations, Title 20, Chapter III, Part 405, Subpart D.

the charge applicable for comparable services under comparable circumstances to the policyholders or subscribers of the carrier. The 1972 amendments provided that increases in the prevailing charge levels would be limited by an economic index furnished by the Bureau of Medicare to all carriers. The economic index relates physicians' fee increases to increases in physicians' practice expenses and increases in the general earnings level.

Allowable charges are updated annually to take into account the actual charges physicians and suppliers have billed for covered services in the preceding calendar year. The revised allowable charge levels go into effect on July 1 of each year or as soon thereafter as they can be incorporated into the carrier's payment system. Thus, for the 12-month period beginning July 1, 1975, allowable charge levels were calculated from actual charge levels for calendar year 1974. However, allowable charges could not exceed the upper limit of the prevailing charges set by law at the 75th percentile of customary charges (weighted by frequency) made for similar services.

Claims for payment of SMI benefits may be submitted to the carrier either by the patient or by the physician or other supplier of services. If the patient submits a claim (an itemized bill) directly to the carrier, he receives direct payment of benefits for covered services; he remains responsible for the physician's (or supplier's) bill. The patient may assign the payment for benefits to a physician or other supplier of services who is willing to accept assignment. In this case, the physician (or supplier) agrees that the allowed or reasonable charge determined by the carrier is the total charge. The physician (or supplier) submits the bill and is reimbursed. In this situation, the patient remains responsible for the remaining 20 percent of the allowed charges for covered services and the $60 deductible (effective 1973), if applicable to the current bill.

Services furnished by group-practice prepayment plans (GPPP's) to members are normally rendered in return for predetermined premium payments. In these cases Medicare reimbursement is made directly to the GPPP. A GPPP which exercises the option provided by law to be paid 80 percent of the reasonable cost of services (in lieu of 80 percent of the allowed charge for such services) generally deals directly with the Health Care Financing Administration. Plans which choose to be paid on the basis of allowed charges are reimbursed by the SMI carrier.

For bills incurred in the SMI portion of the program after March 1968, claims must be filed no later than the close of the calendar year following the year in which the services are furnished. For services provided during the last 3 months of the calendar year, bills may be submitted through the end of the second year following.

HEALTH MAINTENANCE ORGANIZATIONS

The 1972 amendments enabled health maintenance organizations (HMO's) to receive reimbursement from Medicare on a capitation basis for both HI and SMI services. An HMO is an organization which provides to enrolled persons, either directly or by arrangement with others, comprehensive health services on the basis of a periodic rate without regard to the frequency or extent of services furnished to a particular enrollee. For Medicare purposes, an HMO must provide all of the Medicare covered services generally available in its service area.

Prior to the 1972 amendments, HMO-type plans could be reimbursed under Medicare on a capitation basis only for the costs of providing physician's and related SMI services. Plans that also provided inpatient hospital, skilled nursing facility, and home health care as covered benefits to their members billed Medicare through intermediaries and carriers on a fee-for-service basis the same as any other provider. Plans that do not choose or cannot qualify to participate under the HMO option may continue to receive Medicare reimbursement on this basis, under the group practice prepayment plan (GPPP) regulations.

Plans that do not choose to participate under either HMO or GPPP regulations may continue to bill Medicare, through carriers and intermediaries for all Medicare covered services provided to their members who are Medicare beneficiaries. The majority of the existing plans are in this category.

May 1978

National Health Expenditures, Fiscal Year 1977 1/

The following highlights summarize estimates derived from the annual compilation of national health expenditures that are now the responsibility of the Health Care Financing Administration. Several tables containing significant findings are attached. A research report analyzing these current estimates is being prepared by the HCFA staffers and will be featured in the Social Security Bulletin for July 1978.

- The Nation spent $163 billion for health care in fiscal year 1977. These expenditures amounted to $737 for each person in the United States.
- Health care expenditures continue to increase at a greater rate than the gross national product. Fiscal year 1977 spending levels for health care were 12 percent higher than those for the previous 12 months while the GNP increased by 10 percent in the same period. Thus, the health care share of the GNP has increased from 8.7 percent for the year ending September 1976 to 8.8 percent in fiscal year 1977.
- Spending by all governmental programs for health care increased by 11 percent in fiscal 1977, while private spending increased 13 percent. Public spending ($68.4 billion) represented 42 percent of all 1977 money spent for health care.
- Expenditures for hospital care, including both inpatient and outpatient care in public and private hospitals, represented 40 percent of total spending and reached $65.6 billion in fiscal year 1977, a 14 percent increase over the previous year.
- Hospital spending from private sources increased at a greater rate than government spending--15.5 percent compared with 13 percent. All third parties combined--including private health insurers, philanthropy and industry, as well as governments--financed over 94 percent of hospital care in fiscal 1977.

1/ October 1976 through September 1977

- Spending for physicians' services increased 13 percent in 1977, amounting to $32.2 billion or 20 percent of total health spending.
- Outlays for health care benefits by the Medicare and Medicaid programs (HCFA) amounted to $37 billion in fiscal year 1977, 26 percent of the $142.6 billion spent for personal health care (excluding spending for research, construction, public health, and administrative costs).
- For each person receiving Medicare benefits, Medicare spent $1,442; for Medicaid, each beneficiary received an average of $753. Nearly one-fourth of total hospital spending is covered by the Medicare program with an additional 9 percent paid by Medicaid. Nearly 20 percent of expenditures for physicians' services are paid for by the two HCFA programs.

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TABLE 1.--National health expenditures, aggregate and per capita, by source of funds and percent of gross national product, selected years, 1929-1977

Year	Gross national product (in billions)	Health expenditures: Total: Amount (in millions)	Total: Per capita	Total: Percent of GNP	Private: Amount (in millions)	Private: Per capita	Private: Percent of total expenditures	Public: Amount (in millions)	Public: Per capita	Public: Percent of total expenditures
Year ending June										
1929	$101.3	$3,589	$29.16	3.5	$3,112	$25.28	86.7	$477	$3.88	13.3
1935	68.9	2,816	22.04	4.1	2,393	17.84	84.9	543	4.21	19.1
1940	95.4	3,993	29.93	4.1	3,191	23.14	79.9	782	5.84	20.1
1950	264.8	12,027	78.35	4.5	8,962	58.36	74.5	3,065	19.97	25.5
1955	381.0	17,330	103.76	4.5	12,909	77.29	74.5	4,421	26.47	25.5
1960	493.3	25,656	141.63	5.2	19,461	106.60	75.3	6,395	35.03	24.7
1965	658.0	38,892	197.75	5.9	29,357	149.27	75.5	9,535	48.48	24.5
1966	722.4	42,109	211.56	5.8	31,279	157.15	74.3	10,830	54.41	25.7
1967	773.5	47,897	237.93	6.2	32,026	159.15	66.9	15,853	78.78	33.1
1968	830.2	53,765	264.37	6.5	33,725	165.83	62.7	20,040	98.54	37.3
1969	908.2	60,617	295.20	6.7	37,680	183.50	62.2	22,937	111.70	37.8
1970	980.2	69,201	333.57	7.2	43,810	211.18	63.3	25,391	122.39	36.7
1971	1,019.8	77,152	368.25	7.6	48,357	230.91	62.7	28,795	137.32	37.3
1972	1,111.8	85,687	409.71	7.8	53,214	251.61	61.0	33,473	158.20	38.6
1973	1,238.6	95,383	447.31	7.7	58,715	275.35	61.6	36,668	171.96	38.4
1974	1,351.2	106,321	495.01	7.8	64,809	301.74	61.0	41,512	193.27	39.0
1975 1/	1,454.5	123,716	571.21	8.5	71,348	329.42	57.7	52,368	241.79	42.3
1976 3/ 2/	1,629.4	141,013	645.76	8.7	80,831	370.16	57.3	60,182	275.60	42.7
Year ending September										
1975	1,487.1	127,719	588.48	8.6	73,239	337.45	57.3	54,481	251.03	42.7
1976	1,667.4	145,102	663.06	8.7	83,560	381.84	57.6	61,542	281.22	42.4
1977 2/ 3/	1,838.0	162,627	736.92	8.8	94,185	426.78	57.9	68,442	310.13	42.1

1/ Revised
2/ Federal Fiscal Year
3/ Preliminary

TABLE 2.--National health expenditures, by type of expenditure and source of funds, 1975-1977

Type of expenditure	Total	Source of funds: Private			Source of funds: Public		
		Total	Consumers	Other 1/	Total	Federal	State and local
	Year ending September, 1977 2/						
Total	$162,627	$94,185	$87,807	$6,378	$68,442	$46,563	$21,897
Health services and supplies	153,837	91,294	87,807	3,487	62,594	42,542	20,051
Personal health care	142,505	85,465	82,571	2,891	57,121	39,823	17,299
Hospital care	65,627	29,427	27,887	1,540	36,199	25,715	10,484
Physicians' services	32,184	24,360	24,318	42	7,824	5,808	2,016
Dentists' services	10,020	9,520	9,520	0	500	310	190
Other professional services	3,212	2,288	2,175	113	924	683	241
Drugs and drug sundries	12,515	11,373	11,373	0	1,143	614	529
Eyeglasses and appliances	2,006	1,956	1,956	0	130	66	64
Nursing-home care	12,618	5,434	5,343	91	7,184	4,204	2,980
Other health services	4,322	1,105	0	1,105	3,217	2,424	793
Expenses for prepayment and administration	7,572	5,689	5,233	596	1,743	1,430	313
Government public health activities	3,729	0	0	0	3,729	1,289	2,440
Research and medical-facilities construction	8,739	2,891	0	2,891	5,848	4,020	1,828
Research 3/	3,683	284	0	284	3,400	3,139	261
Construction	5,055	2,607	0	2,607	2,448	881	1,567
	Year ending September, 1976						
Total	$145,102	$87,660	$81,470	$6,190	$57,442	$41,648	$15,794
Health services and supplies	136,268	80,712	77,470	3,256	55,642	37,669	17,973
Personal health care	126,217	75,715	73,043	2,698	50,477	34,990	15,488
Hospital care	57,407	25,470	24,013	1,457	32,028	22,538	9,490
Physicians' services	28,504	21,628	21,588	40	6,876	5,059	1,817
Dentists' services	8,987	8,519	8,519	0	468	290	177
Other professional services	2,849	2,142	2,035	107	713	509	204
Drugs and drug sundries	11,472	10,396	10,396	0	1,076	585	491
Eyeglasses and appliances	1,926	1,865	1,865	0	121	65	56
Nursing-home care	10,633	4,713	4,633	80	6,115	3,615	2,500
Other health services	4,038	1,037	0	1,037	3,081	2,329	750
Expenses for prepayment and administration	6,630	4,996	4,427	568	1,645	1,378	265
Government public health activities	3,522	0	0	0	3,522	1,301	2,221
Research and medical-facilities construction	8,734	2,834	0	2,834	5,900	3,979	1,921
Research 3/	3,625	274	0	274	3,348	3,096	252
Construction	5,111	2,560	0	2,559	2,551	883	1,669
	Year ending September, 1975						
Total	$127,719	$73,736	$67,375	$6,362	$54,481	$35,989	$18,493
Health services and supplies	119,771	70,393	67,316	2,924	49,472	32,589	16,883
Personal health care	110,664	65,660	63,241	2,419	45,035	30,290	14,745
Hospital care	49,913	21,710	20,075	1,313	28,626	19,534	9,092
Physicians' services	24,553	18,387	18,348	36	6,171	4,427	1,744
Dentists' services	8,034	7,587	7,587	0	447	270	177
Other professional services	2,463	1,913	1,817	97	550	378	172
Drugs and drug sundries	10,582	9,609	9,609	0	973	510	463
Eyeglasses and appliances	1,822	1,710	1,710	0	112	63	49
Nursing-home care	9,600	4,184	4,107	77	5,436	3,100	2,336
Other health services	3,615	896	0	896	2,720	2,009	711
Expenses for prepayment and administration	6,016	4,670	4,166	506	1,346	1,108	238
Government public health activities	3,091	0	0	0	3,091	1,191	1,900
Research and medical-facilities construction	7,947	2,938	0	2,938	5,009	3,310	1,700
Research 3/	3,132	278	0	278	2,854	2,612	242
Construction	4,815	2,660	0	2,660	2,155	697	1,458

1/ Includes spending by philanthropic organizations and for industrial in-plant health services.
2/ Preliminary estimates.
3/ Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies excluded from "research expenditures" but included in the expenditure class in which the product falls.

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TABLE 3 .--Personal health care expenditures, amounts financed by third parties by type of expenditure, 1975-1977

	Total	Hospital care	Physicians' services	Dentists' services	Other Professional services	Drugs and drug sundries	Eyeglasses and appliances	Nursing-home care	Other health services
Aggregate amount (in millions):				Year ending September 1977 1/					
Total	$142,585	$65,627	$19,184	$10,020	$3,212	$12,516	$2,066	$12,618	$1,322
Direct payments	43,274	3,866	12,502	7,965	1,398	10,401	1,918	5,226	---
Third party payments	91,312	61,761	19,682	2,055	1,814	2,115	169	7,393	4,322
Private health insurance	39,299	24,021	11,817	1,554	777	973	39	118	---
Philanthropy and industrial inplant	2,891	1,540	42	---	113	---	---	91	1,105
Government	57,121	36,199	7,823	501	924	1,142	130	7,184	3,217
Federal	39,823	25,715	5,807	311	683	613	66	4,204	2,424
Medicare	20,770	15,520	4,431	---	457	---	---	362	---
Medicaid	9,181	3,368	1,032	225	184	573	---	3,603	195
Other	9,872	6,827	344	85	42	40	66	238	2,229
State and local	17,299	10,484	2,016	190	241	529	64	2,980	793
Medicaid	7,076	2,596	795	173	142	442	---	2,777	150
Other	10,223	7,888	1,220	17	99	87	64	203	642
Per capita amount:									
Total	$646.11	$297.38	$145.84	$45.41	$14.56	$56.72	$9.45	$57.18	$19.59
Direct payments	196.09	17.52	56.64	36.01	6.34	47.13	8.69	23.68	---
Third party payments	450.02	279.86	89.19	9.31	8.22	9.59	.77	33.49	19.53
Private health insurance	178.08	108.85	53.55	7.04	3.52	4.41	.18	.53	---
Philanthropy and industrial inplant	13.10	6.98	.19	---	.51	---	---	.41	5.01
Government	258.84	164.03	35.45	2.27	4.19	5.18	.59	32.55	14.53
Federal	180.45	116.52	26.32	1.40	3.09	2.78	.30	19.05	10.9
Medicare	94.12	70.33	20.09	---	2.07	---	---	1.64	---
Medicaid	41.61	15.26	4.68	1.02	.83	2.60	---	12.58	.68
Other	44.73	30.93	1.56	.38	.19	.18	.30	1.03	10.10
State and local	78.39	47.51	9.13	.86	1.09	2.40	.29	13.50	3.56
Medicaid	32.06	11.75	3.60	.73	.64	2.01	---	12.58	.68
Other	46.33	35.75	5.53	.08	.45	.39	.29	.92	2.91
Percentage distribution:									
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Direct payments	30.3	5.9	65.2	79.5	43.5	83.1	91.9	41.4	---
Third party payments	69.7	94.1	61.2	20.5	56.5	16.9	8.1	58.6	100.0
Private health insurance	27.6	36.6	36.7	15.5	24.2	7.8	1.9	.9	---
Philanthropy and industrial inplant	2.0	2.3	.1	---	3.5	---	---	.7	83.6
Government	40.1	55.2	24.3	5.0	28.8	9.1	6.2	56.9	71.4
Federal	27.9	39.2	18.0	3.1	21.3	4.9	3.2	33.3	56.1
Medicare	14.6	23.6	13.8	---	14.2	---	---	2.9	---
Medicaid	6.4	5.1	3.2	2.2	5.7	4.6	---	28.6	4.5
Other	6.9	10.4	1.1	.8	1.3	.3	3.2	1.9	51.6
State and local	12.1	16.0	6.3	1.9	7.5	4.2	3.1	22.6	16.3
Medicaid	5.0	4.0	2.5	1.7	4.4	3.5	---	22.0	3.5
Other	7.2	12.0	3.8	.2	3.1	.7	3.1	1.6	14.9

1/ Preliminary

Dollar amounts and percentage distributions may not add to totals due to rounding